

**PRESENTATION TO  
JT. SELECT COMMITTEE ON HEALTH REFORM  
MAY 20, 2010**

**Trish Riley, Director  
Governor's Office of Health Policy and Finance**

A. Foundation for Reform: Maine is well positioned:

- Universal coverage (reaching Maine's uninsured)
- Medicaid to 133% FPL
  - MaineCare already 100% for childless adults
  - Policy options:
    - New costs?
      - Rx rebate
      - Foster children to 26
      - Expansion 100%-133%
    - New savings?
      - CHIP enhanced match
      - Convert parents to Exchange
      - Enhanced match – childless adults
    - Documentation underway – DHHS
- Insurance reforms
  - Many in place now in Maine in whole or in part
  - Work to build consistent state / federal policies
- Exchange – individuals / small businesses to 100
  - Many elements in place
  - Policy options
- Focus on system reform and public health
  - Demonstrations and pilot programs
    - Payment reform
  - Wellness incentives
    - Preventive coverage
    - Premium discounts / incentives
    - Grants - Small business
      - Prevention and Public Health Fund
  - Maine's Public Health Infrastructure – 8 Districts
- Cost Containment
  - Med malpractice demos
  - Payment reform (above)

- Community care and LTC – dual eligibles
- Dirigo assessment
- Quality investments

B. Approach to Implementation

- Executive Branch implementation plan – Executive Order
  - Staff Working Group
  - Steering Committee
    - Karynlee Harrington, Director, Dirigo Health Agency
    - Brenda Harvey, Commissioner, DHHS
    - Anne Head, Director, Licensing and Registration, BOI
    - Mila Kofman, Superintendent, BOI
    - Trish Riley, Chair, Director, Governor's Office of Health Policy and Finance
  - Stakeholders: Advisory Council on Health Systems Development (ACHSD)
- Approach
  - State Health Plan
    - Department and Agency work plans
  - Consultants thanks to HRSA grant
  - Issues and options papers and expert guidance
    - Review and comment – ACHSD
    - Options and recommendations to Governor and Legislature
- Federal – State Liaison
  - NGA Consortium and Steering Committee
  - NAIC and BOI

C. Immediate Opportunities

- High Risk Pool
  - Dirigo Health Agency Board of Trustees
  - Uninsured 6 months and pre-existing condition
  - Standard rates and no pre-existing waiting period
  - \$17 million – 2010-2014
  - Application due 6/1
  - Dirigo Health Agency readiness
- Grant opportunities
- Small business tax credits; reinsurance; young adults; prevention

D. Next Steps: Collaboration with Jt. Select Committee

Characteristics of the Uninsured in Maine Estimates, CPS, All Ages, All Poverty Levels: Calendar Years 2006 - 2008

	Uninsured Population Count	% of Uninsured	Total Population Count	% of Total Population
<b>Age (detailed)</b>				
0-18	17,000	13.6%	298,000	22.7%
19-24	20,000	16.0%	106,000	8.1%
25-44	49,000	39.2%	320,000	24.3%
45-64	38,000	30.4%	392,000	29.8%
65+	1,000	0.8%	200,000	15.2%
<b>Total</b>	<b>125,000</b>	<b>100.0%</b>	<b>1,315,000</b>	<b>100.0%</b>
<b>Poverty Level (detailed)</b>				
0-99% FPL	24,000	19.2%	145,000	11.0%
100-199% FPL	34,000	27.2%	234,000	17.8%
200-399% FPL	44,000	35.2%	449,000	34.2%
400%+ FPL	23,000	18.4%	486,000	37.0%
<b>Total</b>	<b>125,000</b>	<b>100.0%</b>	<b>1,314,000</b>	<b>100.0%</b>
<b>Family Income</b>				
\$0 - \$24,999	47,000	37.6%	303,000	23.0%
\$25,000 - \$49,999	42,000	33.6%	333,000	25.3%
\$50,000 - \$74,999	18,000	14.4%	246,000	18.7%
\$75,000+	18,000	14.4%	434,000	33.0%
<b>Total</b>	<b>125,000</b>	<b>100.0%</b>	<b>1,315,000</b>	<b>100.0%</b>
<b>Work Status - Individual</b>				
Not working	16,000	14.7%	301,000	29.1%
Part-time	25,000	22.9%	173,000	16.7%
Full-time	68,000	62.4%	561,000	54.2%
<b>Total</b>	<b>109,000</b>	<b>100.0%</b>	<b>1,035,000</b>	<b>100.0%</b>
<b>Work Status - Family</b>				
None working	11,000	8.9%	218,000	16.6%
At least one part-time worker	17,000	13.7%	120,000	9.1%
At least one full-time worker	97,000	78.2%	974,000	74.2%
<b>Total</b>	<b>124,000</b>	<b>100.0%</b>	<b>1,312,000</b>	<b>100.0%</b>
<b>Total</b>	<b>125,000</b>		<b>1,315,000</b>	

Source: Current Population Survey Annual Social and Economic Supplement (CPS), 2007 - 2009. The percentages are reported as multi-year averages in order to make the estimates more precise when making state comparisons, as recommended by the U.S. Census Bureau (U.S. Census Bureau 2007). Detail may not add to total due to rounding.







Center for  
Health Law  
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# Patient Protection and Affordable Care Act (H.R. 3590) – Pilot Programs, Demonstration Projects, and Grants

Andrew Cohen

April 2, 2010

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## **Title I—Quality, Affordable Health Care For All Americans**

### *Subtitle B – Immediate Actions to Preserve and Expand Coverage*

#### Promoting Consumer Health Insurance Information (Sec. 1002)

- Award grants to enable states to establish, expand, or support offices of health insurance consumer assistance and state health insurance ombudsman programs.
- To be eligible, states must designate an independent office of health insurance consumer assistance or ombudsperson that receives and responds to inquiries and complaints about health insurance coverage. This agency or program may coordinate with regulatory and/or consumer assistance organizations.
- The agency or program must: assist consumers with filing complaints, grievances, and appeals and with enrollment in plans; collect, track, and quantify consumer problems; educate consumers about their rights and responsibilities regarding health insurance; resolve problems with obtaining premium tax credits.
- HHS Secretary establishes criteria for these grants and collects data reported by the states which can be used in enforcement efforts.
- Funding: \$30m for first FY that law goes into effect (which will remain available without limitation) and authorizes Secretary to appropriate additional funding for future FYs as needed.

#### Supporting states to ensure that consumers get value for their premiums (Sec. 1003)

- Award grants to states during the five year period beginning in FY 2010 to assist with: monitoring of premium increases by the state insurance commissioner; review (and where appropriate) approval of health insurance premium rates; and providing information and recommendations to the state exchange and HHS Secretary.
- In 2014 and beyond: HHS Secretary and states will monitor health insurance premium increases both inside and outside of exchanges.
- Funding: \$250m for Secretary to establish review and monitoring processes with states; remaining funds can be distributed to states to help with planning and implementation of insurance reforms and consumer protections. No state that qualifies for a grant will receive less than \$1m or more than \$5m for a grant year. Grants will be determined based on number of health plans in a state and state population.

### *Subtitle C—Quality Health Insurance Coverage for All Americans*

#### Wellness Program Demonstration Project (Sec. 1201)

- Establish a 10-state demonstration program to promote health and prevent disease, no later than July 1, 2014. If effective, expand demonstration to additional states beginning July 1, 2017.
- 3 years after enactment, Secretary will submit a report to Congress about the project.

*Subtitle D—Available Coverage Choices for All Americans*

Helping States Establish Health Insurance Exchanges (Sec. 1311)

- Provide grants to state to plan and establish health insurance exchanges.
- Grants awarded no later than one year after enactment and may be renewed if the Secretary determines that progress has been made with establishment of exchange and implementation of reforms. States cannot be awarded grants after Jan 1, 2015, after which point Exchanges should be self-sustaining.
- Federal grants will allow states to create a grant program to fund patient navigation and outreach and enrollment activities performed by local organizations. These grants must be funded through operational funds and not the federal grant money.

Loans and Grants to Create Non-Profit Health Insurance Co-Ops (Sec. 1322)

- HHS Secretary provides loans or grants under the Consumer Operated and Oriented Plan (Co-Op) program to foster the creation of non-profit health insurers in the small group and individual markets.
- Give priority to applicants that offer statewide plans, utilize integrated care models, and have significant private support.
- Co-Op programs cannot have previously offered insurance before July 16, 2009 or be sponsored by a state or local government.
- Funding: \$6 billion; must be sufficient to create at least one Co-Op in each state. To be awarded no later than July 1, 2013.
- Sec. 10104 (amendments to subtitle D): loans must be repaid within 5 years and grants within 15 years in a manner that's consistent with solvency requirements and other state rules.

*Subtitle F—Shared Responsibility for Health Care*

Grants to Implement Enrollment Health Information Technology (Sec. 1561)

- Award states or local governments grants to develop new and adapt existing technology systems to implement HIT enrollment standards and protocols.

**Title II—Role of Public Programs**

*Subtitle E—New Options for States to Provide Long-Term Services and Supports*

Medicaid Money Follows the Person Long-Term Care Demonstration (Sec. 2403)

- Extends the MFP rebalancing program through Sept. 2016.
- Allocates \$10m/yr for five years to continue the Aging and Disability Resource Center initiatives (FYs 2010-2014).

*Subtitle H—Improved Coordination for Dual Eligible Beneficiaries*

Medicaid Waiver Demonstration Projects for Dual Eligibles (Sec. 2601)

- Extends these demonstrations for five years, and, upon requests from a state, they can be extended for additional five year periods.

*Subtitle I—Improving the Quality of Medicaid for Patients and Providers*

Medicaid Payment Reform Demonstration Projects

These Grants are made to States and in selecting among State applications, the federal Secretary must seek to “achieve and appropriate national balance in the geographic distribution of such projects.”

Establish a Medicaid Quality Measurement Program (Sec. 2701)

- Appropriation for grants and contracts will be the same as for the pediatric quality measurement program under CHIP.

Planning Grants to Provide Health Homes for Chronically Ill Patients (Sec. 2703)

- Secretary awards grants to states to develop State Plan Amendments to provide health homes for patients with two chronic illnesses, one chronic illness and risk factors for another, or a serious and persistent mental health condition.
- States will include in the state plan amendment methodologies for tracking hospital readmissions or calculating savings from improved care coordination, and a proposal for using health IT in providing health care home services.
- State shall provide a designated provider, a team of health care professionals operating with such a provider, or a health team with payments for the provision of health home services to each eligible individual with chronic conditions that selects the provider or team.
- The Secretary pays each eligible State an amount each quarter equal to the Federal medical assistance percentage of expenditures in the quarter. During the first 8 fiscal year quarters that the State plan amendment is in effect, the Federal medical assistance percentage applicable to such payments shall be equal to 90 percent.
- Funding: \$25 million or less per state.
- Secretary must report to Congress before Jan 1, 2017. Demonstrations will begin Jan 1, 2012 and end on Dec 31, 2016.

Bundled Payments (Sec. 2704)

- Evaluating integrated care around a hospitalization: provides bundled payments for episodes of care that include hospitalizations, incl. physician services provided within a hospital (Jan 1 2012 through Dec 31, 2016).
- To be conducted in up to 8 states. Can be targeted to a specific population, but population should reflect demographic/geographic Medicaid population nationally.
- HHS Secretary must evaluate the Demonstrations and report to Congress



Global Payment Demonstration (Sec. 2705)

- Shift payments to safety net hospital systems from fee-for-service model to a global capitated payment model (FYs2010-2012). “Safety net hospital system” to be defined by the Secretary.
- 5 or fewer states will participate (selection will be made by HHS Secretary).
- Budget neutrality requirements are waived for this demonstration during testing period.
- The Innovation Center (established within CMS – see below) must evaluate and Secretary must report to Congress.

Pediatric ACO Demonstration (Sec. 2706)

- Certain pediatric medical providers would be eligible for incentive payments based on quality and cost savings, Jan 1 2012 through Dec 31, 2016.
- HHS Secretary and states will establish quality guidelines such that the quality of care provided by a pediatric ACO is equal to or greater than what would have been provided.
- States, with the HHS Secretary, must establish a minimum savings level that providers need to attain to receive an incentive payment.
- Providers must participate for at least three years.
- HHS Secretary may cap annual incentive payments.

Medicaid Emergency Psychiatric Demonstration Project (Sec. 2707)

- Provide Medicaid payments to institutions of mental disease for adult enrollees who require stabilization of an emergency condition (Authorized from Oct 2011 through Dec 2015).
- \$75m appropriated for FY2011 and funds are available for five years.
- Demonstration will be conducted for three consecutive years.
- HHS Secretary will ensure a balanced geographic distribution of participating states.
- The federal HHS Secretary must evaluate the demonstration and report to Congress.

*Subtitle L—Maternal and Child Health Services*

Grants for Early Childhood Home Visitation Programs (Sec. 2951)

- Secretary awards grants to states, tribal organizations, or non-profits with a track record of conducting these programs.
- Grant recipients must establish quantifiable and measurable 3- and 5-year benchmarks to demonstrate improvements in maternal and newborn health, prevention of child injuries and abuse, improvements in family economic self-sufficiency and school readiness/achievement, and improvements in coordination and referrals between other community resources.
- Secretary will provide an evaluation of the program to Congress no later than March 31, 2015.
- Funding: \$100m for FY2010, \$250m for FY2011, \$350m for FY2012, \$400m for FY2013, and \$400m for FY2014. At least 3% must go to Indian Tribes or Tribal Organizations.

Providing services to individuals with a postpartum condition and their families (Sec. 2952)

- Award grants to states, local government and/or non-profits to support education and services that diagnose and manage post-partum conditions.
- Projects may deliver or enhance out-patient home-based supports, inpatient supports, quality of available supports, and education about these issues.
- Funding: \$3m for FY2010 and money necessary for FY 2011 and 2012.
- Secretary will report to congress about this program less than two years after enactment.

Education to Promote Personal Responsibility Regarding Sex and Healthy Relationships for Youth (ages 10-20) Populations (Sec. 2953)

- For FY2010 through FY 2014, grants are available to states to reduce pregnancy rates and birth rates among youth populations.
- Each state's allotment will equal at least \$250,000.
- A state must submit an application to receive a grant in FY 2010 or FY 2011 or the state will no longer be eligible to receive these funds (the funds can be appropriated by the Secretary to non-profits within the state, including religious organizations). Emphasis must be on both abstinence and contraception.
- Funding: \$75m for FYs2010-2014, \$10m of which is reserved for youth pregnancy prevention strategies that target services to high-risk, vulnerable, and culturally underrepresented youth populations. 5% of the remainder must be reserved for Indian Tribes or Tribal Organizations. 10% of the remainder is reserved for the Secretary to support and evaluate programs.

**Title III—Improving the Quality and Efficiency of Health Care**

*Subtitle A—Transforming the Health Care Delivery System*

Value-based purchasing demonstration programs (Sec. 3001)

- Establish value-based purchasing demonstration projects under Medicare to test innovative methods of measuring and rewarding quality and efficient health care furnished by critical access hospitals, other hospitals that provide inpatient services,
- Begin the demonstrations no later than 2 years from enactment and conduct them for a three year period. Secretary must submit a report to Congress with recommendations no later than 18 months after completion of the demonstration project.
- Program for hospitals will begin in 2013 and will apply payment for discharges after Oct 1, 2012.

Grants to Develop Quality Measures (Sec. 3013)

- The Secretary may award grants or contracts to support new, or improve existing, efforts to collect and aggregate quality and resource use measures.
- Eligible entities include multi-stakeholder entities that coordinate the development of methods and implementation plans for the consistent reporting of summary quality and cost information; an entity capable of submitting such summary data for a particular population and providers, such as a disease registry, regional collaboration, health plan collaboration, or other population-wide source; or a Federal Indian Health Service program or a health program operated by an Indian tribe.

- Funding for FYs2010-2014. Non-Federal contributions must equal \$1 for every \$5 of federal money.

Create a Center for Medicare and Medicaid Innovation (“CMI”) within CMS (Sec. 3021)

- Test, evaluate, and expand different payment structures and methodologies to reduce program expenditures while maintaining or improving quality of care.
- Payment reform models that improve quality and reduce the rate of cost growth could be expanded throughout the Medicare, Medicaid, and CHIP programs.
- Center for Medicare and Medicaid Innovation (CMI) will be up-and-running by Jan 2011.
- Methods include: payment practice reform and medical home models, coordinating chronic illnesses, moving towards salary-based payment for physicians, utilizing medication therapy management services, establishing community-based health teams and promoting patient self-management, etc.
- Funding: \$5m for FY2010 and \$10b for FYs2011-2019.

Medicare Shared Savings Program, ACOs (Sec. 3022)

- Beginning Jan 1, 2012, permits qualifying groups of physicians and hospitals to be recognized as Medicare ACOs and to share in Medicare cost savings above a certain threshold, provided that certain quality standards are satisfied.
- Secretary of HHS may pay ACOs using a partial capitation model or other payment model that improves quality and efficiency.
- ACOs will use technology to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care

National Pilot Program on Medicare Payment Bundling (Sec. 3023)

- Establishes a national pilot program to for integrated care to develop and evaluate bundled payment for acute inpatient hospital service, physician services, outpatient hospital service, and post-acute care services for an episode of care that begins three days prior to a hospitalization and spans 30 days following discharge.
- Hospitals receive bundled payments for a hospitalization and physician services provided during hospital stay.
- Begins Jan 1, 2013 in up to 8 states. If the pilot program improves (or does not reduce) quality and reduces spending, then develop a plan for expanding the pilot by Jan 1, 2016.
- Pilots will run for five years and can be reauthorized.
- HHS Secretary must conduct an independent evaluation on the pilot program and report to Congress.
- Modified by Sec. 10308:
  - Applies pilot to continuing care hospitals, those that include both acute care and rehabilitation services. Secretary may expand duration and scope of pilot anytime after Jan 1, 2016 if it reduces spending or improves quality.

Independence at Home Medicare Demonstration (Sec. 3024)

- Create demonstration program to provide high-need Medicare beneficiaries with primary care service in their home, delivered by physician- or nurse practitioner-directed primary care teams.
- Allow participating teams of health professionals to share in any savings if they reduce preventable hospitalizations, prevent hospital readmissions, improve health outcomes and efficiency of care, reduce the cost of health services, and achieve patient satisfaction.
- Funding: \$5m per year for FYs2010-2015. Effective Jan 1, 2012.

Hospital Readmissions Reductions Program (Sec. 3025).

- On or after Oct 12, 2012, HHS Secretary can reduce payments to hospitals that have excess readmissions of patients.
- There are special rules for sole community hospitals and Medicare-dependent rural hospitals.

Community-based Care Transitions Program (sec. 3026)

- Funding will be provided to hospitals with high admission rates and certain Community-Based Organizations that improve care transition services for “high-risk Medicare beneficiaries” defined in federal statutory provisions.
- Program will be conducted for 5 years beginning on Jan 1, 2011.
- Funding: \$500m for FYs2011-2015.

Extension of Gainsharing Demonstration (Sec. 3027)

- Originally from Deficit Reduction act of 2005.
- Extended through March 31, 2010 with \$1.6m.

*Subtitle B—Improving Medicare for Patients and Providers*

Demonstration to Separate Payments for Complex Diagnostic Laboratory Tests (Sec. 3113).

- HHS Secretary will conduct a demonstration project under which separate payments are made directly to the labs that analyze specimens in complex diagnostic laboratory tests provided to individuals. Secretary will set the payment rates. These complex tests include analysis of gene protein expression, topographic genotyping, or a cancer chemotherapy sensitivity assay.
- Payments will be made from the Medicare Part B Trust Fund and may not exceed \$100m.
- Funding: Shift \$5m from Medicare Part B Trust Fund to CMS to implement program.
- Secretary will submit a report to Congress no more than two years after the demonstration program is completed.

Extension of Rural Community Hospital Demonstration (Sec. 3123)

- Extends program for five additional years.
- Expands number of states recognized as having “low population densities” to 20.
- Increases maximum number of hospitals that can participate to 30.
- Allows currently participating hospitals to continue their participation for one year.
- Demonstration was initiated by 2003 law that created Medicare Part D; originally authorized for 5 years.

- Modified marginally by Sec. 10313.

Improvements to the Demonstration Project on community health integration models in certain rural counties (Sec. 3126)

- Removes limitation on number of selected counties (current cap of 6).
- Removes references to rural health clinic services and includes physicians' services in scope of demonstration project.

Extension of and revisions to Medicare Rural Hospital Flexibility Program (Sec. 3129)

- Extended through FY2011 and FY2012.
- Funds can be used to help rural hospitals participate in delivery system reforms such as value-based purchasing, ACOs, and payment bundling.

Medicare Hospice Concurrent Care Demonstration Project (Sec. 3140).

- Medicare will use funds that currently pay for hospice to set up hospice care demonstration projects.
- Demonstration project will be authorized for 3 years at 15 or fewer hospice programs representing both rural and urban settings.
- Secretary must conduct an independent evaluation of the Demonstration to determine quality of life, improved patient care, and cost-effectiveness.
- Demonstration must be budget neutral.

*Subtitle C—Provisions Relating to Part C*

Making the Senior Housing Facility Demonstration Permanent (Sec. 3208).

- Service area of a Medicare Advantage Senior housing facility plan can be limited to a specific geographic area.
- Medicare Advantage Senior housing facility plans offer primary care services onsite and have a ratio of accessible physicians to beneficiaries that the Secretary determines is adequate; provide transportation services for beneficiaries to specialty providers outside of the facility; and have participated (as of December 31, 2009) in a demonstration project established by the Secretary under which such a plan was offered for not less than 1 year.

*Subtitle F—Health Care Quality Improvements*

National Quality Strategy

- Develop a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health. Create processes for the development of quality measures involving input from multiple stakeholders and for selecting quality measures to be used in reporting to and payment under federal health programs. (National strategy due to Congress by January 1, 2011)

Create a Center for Quality Improvement and Patient Safety under AHRQ (sec. 3501)

- The center will support research about health care delivery improvement and develop tools to facilitate adoption of best practices that improve system quality, safety, and efficiency.
- Provide technical assistance grants or contracts to help providers and institutions understand, adapt and implement models and practices that promote quality improvements as identified through research. Non-Federal contributions must equal \$1 for every \$5 of federal money.

Establish Community Health Teams to Support Patient-Centered Medical Homes (Sec. 3502)

- Establish a program to provide grants or enter into contracts with eligible entities to establish community-based interdisciplinary, inter-professional teams to support primary care practices, including obstetrics and gynecology practices.
- States or Tribal Organizations are eligible to receive grants.

Grants or contracts to implement medication management services in treatment of chronic diseases (Sec. 3503)

- Awards contracts or grants to programs that provide an appropriate setting, implement a program through local community health teams, etc.
- HHS Secretary will submit a report to Congress that assess clinical effectiveness of pharmacist-provided services, patient/provider satisfaction, impact of cost-sharing, changes in health resources use, etc.

Emergency Care Response Pilot Program (Sec. 3504)

- Grants will be awarded to a state or groups of states to design, implement and evaluate an emergency medical and trauma that coordinates emergency response services within a particular area within a state or multiple states.
- The system must track pre-hospital and post-hospital use of resources and include a region-wide data management system.
- \$24m appropriated for FYs2010-2014.

Grants available to promote access to trauma care services (Sec. 3505)

- HHS Secretary will create three grant programs for Indian Health Service, Indian Tribal, and urban Indian Trauma Centers to defray uncompensated care costs. Secretary will deliver a biannual report to Congress about the programs. Funding: Grants are less than \$2m per grantee per year, \$100m for FY2009 and appropriate amounts each fiscal year through 2015.
- Provide grants to states to support safety net and non-profit trauma centers and consortiums. There is an MOE requirement and no more than 20% of costs can be used for administrative costs. Funding: \$100m for each FY 2010 through 2015.

Grants to Implement of Shared Decision-making using patient aids (Sec. 3506)

- Award grants to health care providers who participate in trainings by Shared Decision-making Resource Centers to develop and implement shared decision-making techniques.
- Funding: authorized for FY2010 and beyond.

Demonstration program to integrate quality improvement and patient safety training into clinical education of health professionals (Sec. 3508)

- Develop and implement academic curricula that integrate quality improvement and patient safety in the clinical education of health professionals.
- Medical schools and other health care training schools are eligible.
- Non-Federal contributions must equal \$1 for every \$5 of federal money.
- HHS Secretary will submit a report to Congress that describes the projects supported by these grants and offers recommendations based on the evaluation of these projects.

Improving Women's Health (Sec. 3509)

- Secretary may make grants to, and enter into cooperative agreements, contracts, and interagency agreements with, public and private entities, agencies and organizations.
- HHS Secretary will submit reports to Congress less than one year after enactment and every two years thereafter.
- Funding: FYs2010-2014. Total period of a grant will not exceed four years.

**Title IV—Prevention of Chronic Disease and Improving Public Health**

*Subtitle A—Modernizing Disease Prevention and Public Health Systems*

National Prevention, Health Promotion and Public Health Council (Sec. 4001)

- Coordinate federal prevention, wellness, and public health activities. Develop a national strategy to improve the nation's health. (Strategy due one year following enactment).
- Create a Prevention and Public Health Fund to expand and sustain funding for prevention and public health programs. (Initial appropriation in fiscal year 2010). Create task forces on Preventive Services and Community Preventive Services to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services. (Effective upon enactment).

Grants to fund outreach campaign regarding preventive benefits (Sec. 4004)

- States or other entities will receive grants to carry out the campaign.
- Funding: Not to exceed \$500m.

*Subtitle B—Increasing Access to Clinical Preventive Services*

Grants to create school-based health centers (Sec. 4101)

- School-based health centers or sponsors of school-based health centers can submit a grant application to the HHS Secretary.
- Preference will be given to school-based health centers that care for high proportions of uninsured children and/or those enrolled in Medicaid and CHIP, as well as to communities that have evidenced barriers to care for children and adolescents regarding primary care, mental health, and substance abuse.
- School-based health centers must provide comprehensive primary care services that include both physical and mental health during school hours.

- Grants can only be used to purchase equipment or build, obtain, or improve facilities; grants cannot be used to pay personnel or provide health services.
- \$50m appropriated for FYs 2010-2013.

Grants to research dental caries prevention and management (Sec. 4102)

- Award demonstration grants to community-based providers to demonstrate the effectiveness of dental caries disease management activities.
- Secretary will use information culled from these projects to inform public information campaign around oral health.
- Funding: FYs2010-2014 to support school-based sealant programs and oral health infrastructure.

Incentives to prevent chronic diseases in Medicaid populations (Sec. 4108)

- Provide grants to states to implement incentive programs to help individuals quit smoking, control/reduce weight, lower cholesterol and blood pressure, avoid diabetes, and address co-morbidities. The purpose is to test approaches that may be scalable.
- States must carry out initiatives within five year period beginning in 2011 and submit semi-annual reports to the HHS Secretary as well as a final report due before July 1, 2016.
- Funding: \$100m for five year period beginning on Jan 1, 2011.

*Subtitle C—Creating Healthier Communities*

Community Transformation Grants (Sec. 4201)

- A State agency, local government agency, national network of community-based organizations, a state or local non-profit organization, or an Indian tribe can apply for money to implementation, evaluation, and dissemination of evidence-based community preventive health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming.
- Funding: appropriations for FYs 2010-2014.

Promoting healthy aging and living well (Sec. 4202)

- Award grants to State or local health departments and Indian tribes to carry out 5-year pilot programs to provide public health community interventions, screenings, and where necessary, clinical referrals for individuals who are between 55 and 64 years of age.
- Evaluation by HHS Secretary due to Congress no later September 30, 2013.
- Funding: transfer \$50m from the Medicare Trust funds to CMS; FYs2010-2014.

Demonstration to Improve Immunization Coverage (Sec. 4204)

- Award grants to States to improve the provision of recommended immunizations for children, adolescents, and adults through the use of evidence-based, population-based interventions for high risk populations.
- States must submit grant applications to the HHS Secretary and funds must be used to implement evidence-based interventions recommended by the Task Force on Community Preventive Services.



- Less than three years after receiving grants, states must submit a report to the Secretary. Secretary must submit a report to Congress within four years after enactment.
- Funding: FYs2010-2014.

#### Wellness Demonstration (Sec. 4206)

- Creates demonstration project to implement, evaluate, and disseminate evidence-based community preventive health activities to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming.
- Establishes 10-state pilot programs by July 2014 to permit participating states to apply rewards for participating in wellness programs in the individual market. (The bill permits employers to offer employees rewards in the form of premium discounts, waiver of cost sharing, or extra benefits for meeting some health-related standards).
- Expands demonstrations in 2017 if effective. Require a report on the effectiveness and impact of wellness programs. (Report due three years following enactment).

#### *Subtitle D—Support for Prevention and Public Health Innovation*

#### Data collection about disparities (sec. 4302)

- Require enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations. Also require collection of access and treatment data for people with disabilities. Require the Secretary to analyze the data to monitor trends in disparities. (Effective two years following enactment)

#### Epidemiology-Laboratory Capacity Grants (Sec. 4304)

- The HHS Secretary, working through the Director of the Center for Disease Control and Prevention, will establish this grant program.
- Grants available to state and local health departments as well as tribal jurisdictions.
- Academic centers that assist these entities may also be eligible for funding as determined by the Director.
- Grants will be awarded to assist public health agencies to strengthen epidemiologic capacity, enhance laboratory capacity, improve information systems, and develop and implement infection control strategies.
- Funding: \$190m for FYs 2010-2013. At least \$95m must be available for strengthening epidemiologic capacity and developing/implementing infection control strategies; \$60m for improving information systems; \$32m for enhancing laboratory capacity.

#### Advancing Research and Treatment for Pain Care Management (Sec. 4305)

- The Secretary may make awards of grants, cooperative agreements, and contracts to health professions schools, hospices, and other public and private entities for the development and implementation of programs to provide education and training to health care professionals in pain care.
- Funding: Appropriate for FYs 2010-2012.

Funding for Childhood Obesity Demonstration Project (Sec. 4306)

- Appropriates \$25m for FYs2010-2014.

**Title V – Health Care Workforce**

Purpose: Improve access to and the delivery of health care services for all people, and particularly underserved and vulnerable populations, through research, improving workforce capacity, personnel training, and support.

*Subtitle B – Innovations in the Health Care Workforce*

National Health Care Workforce Commission (Sec. 5101)

- Creates the Commission to develop and commission worker education and training activities; identify barriers to communication between levels of government and serve as a resource for federal, state, and local governments.

State health care workforce development grants (Sec 5102)

- Establishes a competitive health care workforce development grant program to enable state partnerships to complete comprehensive planning and to carry out activities leading to coherent and comprehensive health care workforce development strategies at the state and local levels.
- Max. grant of \$150,000 per award.

*Subtitle C – Increasing the Supply of the Health Care Workforce*

Grants for training of mid-career public and allied professionals (sec. 5206)

- Enables Secretary to award grants to universities and other educational entities to offer additional training in the field of public health and allied health to mid-career professionals in this workforce.
- Funding: \$60m for FY 2010 and as necessary for FY 2011-2015; 50% for allied health and 50% for public health professionals.

Demonstration Supporting Nurse-Managed Clinics and FQHCs (Sec. 5208)

- Creates demonstration through which grants would be available to FQHCs and nurse-managed health clinics that train family nurse practitioners.
- Funding: \$50m for FY2010 and as necessary for FY 2011-2014.

Support and Development of primary care training programs (Sec. 5301)

- HHS Secretary will award grants to medical schools or other non-profit physician training programs to plan, develop, and operate programs that train physicians to practice family medicine, general internal medicine, or general pediatrics, as well as promote teaching of these fields in community settings. Also provides financial assistance to participants of these programs.
- Create demonstration projects to train primary care physicians to work in patient-centered medical homes; also develop curriculum.

- Medical schools and schools of osteopathy that establish new academic units or substantially expand such units or programs will be favored for grants, as will schools that have a track record in doing this work and caring for vulnerable populations.
- Funding: \$125m for FY 2010, and additional funds as necessary for FYs 2011-2014. Grants or contracts will be given out for five years.

Training opportunities for direct care workers (Sec. 5302)

- Award grants to provide new training opportunities for direct care workers who are employed in long-term care settings such as nursing homes, assisted living facilities and skilled nursing facilities, intermediate care facilities for individuals with mental retardation, home and community based settings.
- Grants will be awarded to universities that have established public-private educational partnerships with the institutions mentioned above.
- Use grants to offset fees and tuition for individuals in this workforce.
- Funding: \$10m for FYs 2011-2013.

Supporting Dental Training Programs (Sec. 5303)

- Secretary will award grants or enter into contracts with schools of dentistry, non-profit hospitals, or other non-profit entities to develop dental training programs and provide financial aid to dental students and hygienists.
- Priority will go to partnerships between departments of primary care and dental schools, those that treat vulnerable populations, particularly at community health centers.
- Funding: \$30m for FY2010 and as appropriate FYs 2011-2015, grant payments will be made over five years and be subject to annual approval.

Alternative dental health care providers demonstration project (Sec. 5304)

- Establishes training programs to train, or to employ, alternative dental health care providers to increase access to dental health care services in rural and other underserved communities.
- 15 projects to begin no later than 2 years after enactment and conclude less than 7 years from enactment.
- Funding: Each grant will be at least \$4m over five years.

Geriatric Workforce Development (Sec. 5305)

- Secretary will award grants or contracts to entities that operate geriatric education centers. These centers will provide short-term courses that focus on geriatrics, chronic care management, and long term care and provide supplemental training for faculty members in medical schools and other health professions schools. These courses will count towards continuing medical education credits. Also offer at least two courses per year for family caregivers.
  - Funding: Awards are \$150,000 per center and no more than 24 awards may be given; \$10.8m for FYs 2011-2014.
- Geriatric Career Incentive awards for individuals who will teach or practice in the field of geriatric medicine for at least 5 years.
  - Funding: \$10m for FYs 2011-2013.
- Expansion of eligibility for geriatric academic career awards; payments go to medical schools.

Mental and behavioral health education and training grants (Sec. 5306)

- Secretary will award grants to medical schools and other institutions of higher learning to support recruitment, education, and clinical experience of students in the fields of mental and behavioral health.
- Funding for FYs 2010-2013: \$8m for training in social work, \$12m for training in graduate psychology, \$10m for training in child and adolescent mental health, \$5m for training in paraprofessional child and adolescent mental health.

Grants for cultural competency, prevention, public health and working with individuals with disabilities (Sec. 5307)

- Award grants for development, evaluation, and dissemination of research, demonstration projects, and model curricula for cultural competency, prevention, public health proficiency, reducing health disparities, and aptitude for working with individuals with disabilities training for use in health professions schools and continuing education programs.
- Funding: necessary appropriations authorized for FYs 2010-2015.

Advanced nursing education grants (Sec. 5308)

- Supports accredited nurse-midwifery training programs.

Nurse education, practice, and retention grants (Sec. 5309)

- Secretary will award grants or contracts to accredited schools of nursing or a partnership between a school and a nursing facility to enhance the nursing workforce by initiating or enhancing nurse retention programs; also promotes collaboration and communication between nurses and other medical professionals.
- Secretary will report on these programs to Congress before the end of each FY.

Grants to promote the community health workforce (Sec. 5313)

- The Director of the Centers for Disease Control and Prevention, in collaboration with the HHS Secretary, will award grants to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of community health workers.
- Prioritize applicants that work with underserved, vulnerable, and chronically-ill populations
- Encourage CHW programs to collaborate with academic institutions and one-stop delivery systems.
- Encourage implementation of a process or an outcome-based payment system that rewards community health workers for connecting underserved populations with the most appropriate services at the most appropriate time.
- Secretary shall establish guidelines for assuring the quality of the training and supervision of community health workers to ensure cost-effectiveness.
- Funding: Appropriations as necessary for FYs 2010-2014.

Fellowship Training in Public Health (Sec. 5314)

- Grants to support fellowship training in epidemiology and public health.

- Funding: \$35.5m for FYs2010-2013; \$5m for epidemiology fellowship training; \$5m for lab fellowship training; \$5m for Public Health Informatics Fellowship Program through the CDC; \$24.5m for the Epidemic Intelligence Service.

#### Supporting US Public Health Sciences (Sec. 5315)

- Surgeon General will enter into contracts with, accept grants from, and make grants to any nonprofit entity for the purpose of carrying out cooperative enterprises in medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing research, consultation, and education.

#### *Subtitle E – Supporting the Existing Health Care Workforce*

##### Centers of Excellence (Sec. 5401)

- Grants for health professions schools that meet particular criteria.
- Funding: \$50m for FYs 2010-2015.

##### Supporting area health education centers (Sec. 5403)

- Infrastructure development award and point of service maintenance and enhancement award, particularly for medical schools. Funding: \$125m for FY 2010-2014; not less than \$250,000 per AHEC annually; limited to 12 years for a program and 6 years for a center.
- Grants for health professionals working in underserved communities: Improve health care, increase retention, increase representation of minority faculty members, enhance the practice environment, and provide information dissemination and educational support to reduce professional isolation through the timely dissemination of research findings using relevant resources. Funding: \$5m for each FY 2010 through 2014.

##### Workforce Diversity Grants (Sec. 5404)

- Grants to establish state hubs and local primary care extension agencies.
- Secretary shall award competitive grants to States for the establishment of State- or multistate-level primary care Primary Care Extension Program State Hubs.
- Hubs must include at least the State health department, the entities responsible for administering the State Medicaid program Medicare within the state, and the departments of 1 or more health professions schools in the State that train providers in primary care; may include hospital associations or health professional societies.
- Develop implementation of a hub for 6 years
- Funding: \$120m for FY2011-2012, appropriations as necessary for FY 2013 and 2014.

#### *Subtitle F – Strengthening Primary Care and Other Workforce Improvements*

##### Demonstration projects to address health professions workforce needs (Sec. 5507)

- Grants to states or Tribes to provide low income individuals with opportunities for education, training, and career advancement to address health professions workforce needs.
- Develop training and certification programs for personal or home care aides; duration for at least 3 years.
- Secretary will report to Congress within one year after completion of the project.

- Funding: \$85m for FYs2010-2014; \$5m of this amount for training and certification programs for personal and home health aides FY2010-2012.

Increasing Teaching Capacity (Sec. 5508)

- Award grants to teaching health centers for the purpose of establishing new accredited or expanded primary care residency programs. Funding: \$25m for FY 2010, \$50m for FY 2011, \$50m for FY 2012; no more than \$500,000 per grantee for no more than three year period.
- Payments to teaching health centers that operate graduate medical programs. Funding: No more than \$230m for FYs 2011-2015.

Medicare Graduate Nurse Education Demonstration Program (Sec. 5509)

- Eligible hospitals receive Medicare reimbursement for clinical training costs for training advance practice nurses
- Funding: \$50m for each of fiscal years 2012 through 2015 to carry out this section, including the design, implementation, monitoring, and evaluation of the demonstration.

*Subtitle G – Improving access to health care services*

Spending for FQHCs (Sec. 5601)

- Fiscal year 2010, \$2,988,821,592, fiscal year 2011, \$3,862,107,440, fiscal year 2012, \$4,990,553,440, fiscal year 2013, \$6,448,713,307, fiscal year 2014, \$7,332,924,155; fiscal year 2015, \$8,332,924,155; fiscal year 2016, and each subsequent fiscal year, the amount appropriated for the preceding fiscal year adjusted by the product of—(i) one plus the average percentage increase in costs incurred per patient served; and (ii) one plus the average percentage increase in the total number of patients served.

Co-locating primary and specialty care in community-based mental health settings (sec. 5604)

- Establish demonstration projects for the provision of coordinated and integrated services to adults with mental illness who have co-morbidities through the co-location of primary and specialty care services in community-based mental and behavioral health settings.
- Funding \$50m for FY 2010, and appropriations as necessary for FYs2011-2014.

**Title VI – Transparency and Program Integrity**

*Subtitle B—Nursing Home Transparency and Improvement*

National independent monitor demonstration project (Sec. 6112)

- Develop, test, and implement an independent monitor program to oversee interstate and large intrastate chains of skilled nursing facilities and nursing facilities.
- 2-year period of demonstration, takes effect one year after passage.

National demonstration projects on culture change and use of information technology in nursing homes (Sec. 6114)

- 2 demonstration projects, 1 for the development of best practices in skilled nursing facilities and nursing facilities that are involved in the culture change movement (including the development of resources for facilities to find and access funding in order to undertake culture change)
- 1 for the development of best practices in skilled nursing facilities and nursing facilities for the use of information technology to improve resident care.
- Conduct demonstrations for less than three years.

*Subtitle C—Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-term Care Facilities and Providers*

Nationwide program for national and state background checks on direct patient access employees of long-term care facilities and providers (Sec. 6201)

- Establish a program to identify efficient, effective, and economical procedures for long term care facilities or providers to conduct background checks on prospective direct patient access employees on a nationwide basis.
- Funding: payment to each new participating state will be three times what the state has made available for the program, up to \$3m; old participating states have a cap of \$1.5m. total: no more than \$160m for FYs 2010-2012. Can reserve up to \$3m for the evaluation.
- Inspector General of HHS will conduct an evaluation of the programs and submit a report to Congress.

*Subtitle D—Patient-Centered Outcomes Research*

Patient-centered outcomes research (sec. 6301)

AHRQ will build capacity for comparative clinical effectiveness research by establishing a grant program that provides for the training of researchers in the methods used to conduct such research, including systematic reviews of existing research and primary research such as clinical trials.

Funding: build a Patient-Centered Outcomes Research Trust Fund. \$10m for FY2010, \$50m for FY2011, \$150m for FY2012; 2013-2019: amount equivalent to collected fees on health insurers and self-insured plans and \$150m.

*Subtitle H—Elder Justice Act*

Grants to support the Long Term Care Ombudsman Program and adult protective services (Sec. 6703)

“Sec. 2046”: Rule of Construction, grants to survey skilled nursing facilities.

- Grants to state agencies that perform surveys of skilled nursing facilities. Design and implement complaint investigation systems that optimize collaboration between providers, consumers, and authorities and respond promptly and effectively to complaints.
  - Funding: \$5m each year for FY2011-2014.

“Sec. 2042”: Adult Protective Services

- The HHS Secretary will provide funding and technical assistance to state and local adult protective services agencies; collect and disseminate data annually about abuse and exploitation of elders; develop information about best practices and provide training opportunities.
  - Funding: \$3m for FY 2011 and \$4m for each FY 2012-2014.
- Establish an adult protective services grant program to award annual grants to states and local governments.
  - Funding: \$100m for FYs 2011-2014; each state can get an amount equal to the percentage of total elders in the state multiplied by 0.75 of the amount appropriated that year.
- Fund states to create demonstration projects to test: training modules that detect or prevent elder abuse and financial exploitation of elders; methods to detect abuse; evaluation of whether these trainings work. Each grantee will submit a report to the HHS secretary.
  - Funding: \$25m for FYs 2011-2014.

“Sec. 2043”: Long-term care ombudsman

- Make grants available for long-term care facilities and other long term care entities as determined by the Secretary to improve the capacity of State long term care ombudsman programs to respond to and resolve complaints about abuse and neglect. Also, conduct pilot programs with State long-term care ombudsman offices or local ombudsman entities and provide support to these programs.
  - Funding: \$5m for FY 2011, \$7.5m for FY 2012, \$10m for FYs 2013 and 2014.
  - Funding for ombudsman training programs: \$10m for each FY 2011-2014.

“Sec. 2044”: Provision of information regarding, and evaluations of, elder justice programs.

“Sec. 2031”: Forensic Centers for detecting elder abuse, neglect, and exploitation.

- The Secretary, in consultation with the Attorney General, shall make grants to eligible entities to establish and operate stationary and mobile forensic centers, to develop forensic expertise regarding, and provide services relating to, elder abuse, neglect, and exploitation. Four grants for institutions of higher education with demonstrated expertise in forensics or commitment to preventing or treating elder abuse, neglect, or exploitation, to establish and operate stationary forensic centers. Six grants for mobile forensic centers.
  - Funding: \$4m for FY 2011, \$6m for FY 2012, \$8m for each FY 2013 and 2014.

“Sec. 2041”: Enhancement of Long Term Care.

- Certified EHR Technology Grant Program. Provide grants to long-term care facilities for the purpose of assisting such entities in offsetting the costs related to purchasing, leasing, developing, and implementing certified EHR technology designed to improve patient safety and reduce adverse events and health care complications resulting from medication errors.
  - Funding: \$20m for FY 2011, \$17.5m for 2012, \$15m for each FY 2013 and 2014.
- Long term care staffing. Provide grants and incentives to enhance training, recruitment and retention of long-term care staff. Provide training and technical assistance regarding management practices using methods that are demonstrated to promote retention of individuals who provide direct care. Provide financial incentives for achieving certification to LTC aides.
  - Funding: \$20m for FY 2011, \$17.5m for 2012, \$15m for each FY 2013 and 2014.



Medical Malpractice (Sec. 6801)

- See Sec. 10607.

**Title IX—Revenue Provisions**

*Subtitle B—Other Provisions*

Qualifying therapeutic discovery project credit (Sec. 9023)

- Provide grants and tax credits to businesses with fewer than 250 employees that undertake a qualifying therapeutic discovery project to: 1) treat or prevent diseases or conditions by conducting pre-clinical activities, clinical trials, and clinical studies, or carrying out research protocols, for the purpose of securing approval of a product by the FDA; b) diagnose diseases or conditions or to determine molecular factors related to diseases or conditions by developing molecular diagnostics to guide therapeutic decisions; or c) develop a product, process, or technology to further the delivery or administration of therapeutics.
- Priority goes to projects that develop new therapies that address long-term care needs and chronic illness, especially working to cure cancer.
- Funding: No more than \$1b for two year period beginning with 2009.

**Title X—Strengthening Quality, Affordable Health Care for All Americans**

*Subtitle B—Provisions related to Title II*

Support for parenting and pregnant teens and women (sec. 10211-10213)

- States will receive grants to supplement spending by institutions of higher learning that operates or agree to establish a pregnant and parenting student services office. At least one quarter of spending must be from non-Federal sources. Grants can be used to conduct a needs assessment, provide direct services, create referral patterns with other organizations, and assess the performance of students regarding these issues.
- States can also use grants to fund high schools and community service centers to establish, maintain or operate pregnant and parenting services.
- States can also make funding available to the state attorney general to improve services for pregnant women who are victims of domestic violence, sexual violence, sexual assault, and stalking. The AG can fund law enforcement, intervention services, technical assistance and training for non-profit organizations, local or federal governments, faith-based organizations, or professionals working in law, health care, or social services.
- Funds can also be used to promote public awareness and education about these issues.
- Funding: \$25m for each FY 2010-2019.

*Subtitle C—Provisions Relating to Title III*

Plans for a Value-Based purchasing program for ambulatory surgical centers (Sec. 10301)

- Requires Secretary of HHS to Issue a plan by Jan 1, 2011 to develop value-based purchasing program for ambulatory surgical centers, skilled nursing facilities, and home health agencies.

Data Collection and Public Reporting (Sec. 10305)

- Secretary will collect and aggregate consistent data on quality and resource use measures from information systems used to support health care delivery, and may award grants or contracts for this purpose. The Secretary shall align such collection and aggregation efforts with the requirements and assistance regarding the expansion of health information technology systems, the interoperability of such technology systems, and related standards.

Revisions to Payment Bundling Pilot (Sec. 10308)

- Applies pilot to continuing care hospitals for full episodes of care, which is defined as the full period that a patient stays in the continuing care hospital plus the first 30 days following discharge from the hospital.
- Continuing Care hospitals are those that demonstrate the ability to meet patient care and patient safety standards and provide under common management the medical and rehabilitation services provided in inpatient rehabilitation hospitals and units, long term care hospitals, and skilled nursing facilities.

Medicare demonstration based on the study of home health agencies (Sec. 10315)

- Conduct demonstration to test whether making payment adjustments for home health services under the Medicare program would substantially improve access to care for patients with high severity levels of illness or for low-income or underserved Medicare beneficiaries.
- Waive budget neutrality for this demonstration.
- Conduct it for four years beginning no later than Jan 1, 2015. If the demonstration goes forward, Secretary will evaluate the program and report to Congress.
- Funding: \$500m from Medicare Trust Funds for FYs 2015-2018—funding available for the study and the demonstration.

Pilot for care of individuals exposed to environmental health hazards (Sec. 10323)

- Establish a pilot program to provide innovative approaches to furnishing comprehensive, coordinated, and cost-effective care for these people.
- Funding: Transfer money to CMS from the Medicare Trust Funds as the Secretary deems necessary.

Pilot testing pay-for-performance programs for certain Medicare providers (Sec. 10326)

- Not later than Jan 1, 2016, run a pilot program to test value-based purchasing for particular providers: psychiatric hospitals, LTC hospitals, hospice programs, certain cancer hospitals, rehabilitation hospitals.
- Secretary can expand the duration or scope of pilot at any time after January 1, 2018.

Financial incentives to choose high-quality providers (Sec. 10331)

- Establish a demonstration program to provide incentives to Medicare beneficiaries who choose high-quality providers
- Begin no later than Jan 1, 2019. Medicare beneficiaries cannot be required to pay higher cost-sharing or have reduced benefits because of the demonstration.

Community-based collaborative care network program (Sec. 10333)

- Secretary may award grants to eligible entities to support community-based collaborative care networks (consortium of health care providers with a joint governance structure) to provide comprehensive coordinated and integrated health care services for low-income populations.
- Priority given to networks that have: the capability to provide the broadest range of services to low-income individuals; the broadest range of providers that currently serve a high volume of low-income individuals; and county or municipal departments of health.
- Grants can be used for outreach and enrollment, patient navigation and care coordination, case management, transportation, expanded capacity for tele-health or after-hour services.
- Funding: appropriations as necessary for FYs2011-2015.

Office of Minority Health (Sec. 10334)

- Secretary will award grants, contracts, etc with public and nonprofit private entities, agencies, etc to assure improved health status of racial and ethnic minorities, and shall develop measures to evaluate the effectiveness of activities aimed at reducing health disparities and supporting the local community. Such measures shall evaluate community outreach activities, language services, workforce cultural competency.
- Funding: As necessary for FY 2011-2016.
- Secretary will report to Congress less than one year after enactment and biennially after that.

*Subtitle D—Provisions Relating to Title IV*

Grants for small businesses to provide comprehensive workplace wellness programs (Sec. 10408)

- Secretary shall award grants to employers with fewer than 100 employees all of whom work 25 or more hours per week to provide their employees with access to comprehensive workplace wellness programs. Programs include health awareness initiatives, efforts to maximize employee engagement, initiatives to change healthy behaviors and support healthy workplace environments.
- Grant program will be conducted for five years. Eligible employers must submit an application to the Secretary.
- Funding: \$200m for FYs2011-2015. Money will remain available until expended.

Cures acceleration network (Sec. 10409)

- Director of NIH shall award grants and contracts to accelerate the development of high need cures, including through the development of medical products and behavioral therapies.
- Recipients can include private or public research institutions, institutions of higher education, medical centers, biotechnology companies, pharmaceutical companies, disease advocacy organizations, patient advocacy organizations, or academic research institutions.
- Funding: \$500m for FY2010 and as necessary after that. Awards will not be more than \$15m per project for the first FY of funding; can receive additional funding of up to \$15m for subsequent years. Non-federal funds for projects must equal at least one of every three dollars spent.
- Director of NIH may audit awardees and has flexible research authority to use up to 20% of funds.

Centers of Excellence for Depression (Sec. 10410)

- Award grants on a competitive basis to institutions of higher education or public or private nonprofit research institutions to establish national centers of excellence for depression to engage in activities related to the treatment of depressive disorders.
- By September 30, 2016 not more than 30 centers should be established.
- Grant period is five years and may be renewed on a competitive basis for another 1 to 5 years.
- Priority for grants given to entities that have: a) demonstrated capacity and expertise to serve the targeted population, b) existing infrastructure or expertise to provide appropriate, evidence-based and culturally and linguistically competent services, c) a location in a geographic area with disproportionate numbers of underserved and at-risk populations in medically underserved areas and health professional shortage areas, d) proposed innovative approaches or outreach to initiate or expand services, e) use of the most up-to-date science, practices, and interventions available, f) demonstrated capacity to establish cooperative and collaborative agreements with community mental health centers and other community entities to provide mental health, social, and human services to individuals with depressive disorders.
- Non-federal contributions must be 1 of every 5 dollars spent on the project.
- Funding: \$100m for each FY 2011-2015, \$150m for each FY 2016-2020. Allocation to each center may be no more than \$5m except for the coordinating center which may receive up to \$10m.

National congenital heart disease surveillance system (sec. 10411)

- Award one grant to enhance and expand infrastructure to track the epidemiology of congenital heart disease and to organize such information into a nationally-representative, population-based surveillance system that compiles data concerning actual occurrences of congenital heart disease, to be known as the National Congenital Heart Disease Surveillance System. Eligible entity must be a public or private non-profit with specialized experience in congenital heart disease.
- Funding: appropriations as necessary FYs2011-2015.

Young women's breast health awareness and support of young women diagnosed with breast cancer (Sec. 10313)

- Conduct a national evidence-based education campaign to increase awareness of young women's (ages 15-44) knowledge regarding breast health in young women of all racial, ethnic, and cultural backgrounds; the occurrence and risk factors for cancer, etc.
- Award grants to entities to establish national multimedia campaigns oriented to young women that may include advertising through television, radio, print media, billboards, posters, all forms of existing and especially emerging social networking media, other Internet media, and any other medium.
- Award grants to organizations and institutions to provide health information from credible sources and substantive assistance directed to young women diagnosed with breast cancer and pre-neoplastic breast diseases.
- Funding: \$9m for each FY 2010-2014.

*Subtitle E—Provisions Relating to Title V*

Demonstration grants for family nurse practitioner training programs (Sec. 10501)

- Establish a training demonstration program for family nurse practitioners to employ and provide 1-year training for nurse practitioners who have graduated from a nurse practitioner program for careers as primary care providers in Federally Qualified Health Centers and Nurse-Managed Health Clinics.
- Create a FQHC and NMHC training module for NPs that can be replicated nationwide.
- Award 3-year grants to FQHCs and NMHCs that have sufficient infrastructure to train a minimum of 3 nurse practitioners per year and to provide to each awardee with 12 full months of full time, paid employment and benefits. Entities must provide NPs with specialty training and rotations among high-volume/high-risk populations. Encourage collaboration with medical schools and other health professional training programs.
- Secretary can award a technical assistance grant to one or more FQHCs/NMHC that has demonstrated expertise in establishing an NP residency program.
- NP recipients must demonstrate a commitment to a career in FQHCs/NMHCs and be licensed/board-certified; preference for bi-lingual NPs.
- Funding: no more than \$600,000 per entity; can roll-over money from one FY to another. Appropriations as necessary for FYs 2011-2014.

State grants to health care providers who provide services to a high percentage of medically underserved populations or other special populations (Sec. 10501)

- A State may award grants to health care providers who treat a high percentage of medically underserved populations or other special populations. The program cannot be established under the state Medicaid program.
- The goal is to recruit students most likely to practice in medically underserved areas, particularly rural communities, provide rural-focused training and experience, and increase the number of recent allopathic and osteopathic medical school graduates.
- Recipients must establish or expand a rural-focused training program, enroll no fewer than 10 students per year in the program, and prioritize students who have lived in underserved rural communities for two years or more. An annual report from each grantee is due to the Secretary of HHS.
- Funding: \$4m for FYs 2010-2013.

Preventive Medicine and public health training grant program (Sec. 10501)

- Award grants to schools of medicine, public health, osteopathic medicine, accredited public or private non-profit hospitals, and state, local or tribal department of health to provide preventive care training to medical residents.
- HHS Secretary will submit an annual report to congress about this program.
- Funding: \$43m for FY2011 and as necessary for FYs2012-2015.

Grants for community-based diabetes prevention programs (Sec. 10501)

- Establish a national diabetes prevention program targeted at adults at high risk for diabetes to eliminate the preventable burden of diabetes.
- Funding: appropriations as necessary, FYs 2010-2014.

Infrastructure to expand access to care (Sec. 10502)

- Appropriate \$100m for fiscal year 2010, to remain available for obligation until September 30, 2011, to be used for debt service on, or direct construction or renovation of, a health care facility that provides research, inpatient tertiary care, or outpatient clinical services. Such facility shall be affiliated with an academic health center at a public research university in the United States that contains a State's sole public academic medical and dental school.

Demonstration project to provide access to affordable care (sec. 10504)

- Establish a 3 year demonstration project in up to 10 States to provide access to comprehensive health care services to the uninsured at reduced fees.
- Secretary shall evaluate the feasibility of expanding the project to additional States.
- Eligible entities must be nonprofit, public-private partnerships that provide access to comprehensive health care services to the uninsured at reduced fees.
- Each participant will receive no more than \$2m to carry out the demonstration over three years.

*Subtitle F—Provisions Relating to Title VI*

Medical Malpractice Demonstration (Sec. 10607)

- Evaluates alternatives to current medical tort litigation.
- States will receive 5-year grants to develop tort litigation alternatives that allow for dispute resolution and promote reduction in health care errors.
- Preference will be given to state that have developed alternatives in consultation with relevant stakeholders and have proposals that are likely to improve access to liability insurance and enhance patient safety by reducing medical errors.
- Permits patients to opt out and pursue remedies through the courts.
- Funding: \$50m for five FY period beginning FY2011; up to \$500,000 per state for planning grants.

## **Payment Reform Opportunities in the Patient Protection and Affordable Care Act**

- Effective January 1, 2014, the Secretary shall define and annually update an **essential health benefit package**. All qualified health benefit plans, both those offered through the Exchange and those offered in the individual and small group markets outside the Exchange except for grandfathered plans, must offer at least the essential health benefit package. All policies offered through the Exchange must comply with one of the four benefit categories. (2012)
- Allow providers organized as **Accountable Care Organizations** that voluntarily meet quality thresholds to share in cost savings they achieve in Medicare. To qualify, an ACO must be accountable for overall care of Medicare beneficiaries, have adequate participation of primary care physicians, use evidence based medicine, and report on quality and costs and coordinate care. (January 1, 2012)
- **Creation of an Innovation Center within CMS** to test, evaluate and expand Medicare, Medicaid and CHIP payment structures and methodologies, to reduce program expenditures while maintaining or improving quality of care. (January 1, 2011)
- **Reduce Medicare payments that would otherwise be made for preventable hospital admissions.** (Medicare 10-1-2012) Reduce Medicare payments to hospitals for hospital acquired conditions by 1% effective. (FY 2015)
- **Prohibit federal payments to states for Medicaid services related to health care acquired conditions.** (July 2011)
- **Establish a national Medicare pilot program to develop and evaluate a bundled payment for acute, in-patient physician, out-patient and post-acute care for an episode of care** that begins 3 days prior to hospitalization and spans 30 days following discharge. The pilot program will be expanded if it meets goals of improving or not reducing quality and reducing spending. Pilot program established (January 2013); expand program as appropriate (January 2016).
- Create **independence at home demonstration in Medicare** to provide high need beneficiaries with primary care in their homes and allow participating teams of health professionals to share in any savings if they reduce preventable hospitalizations, prevent hospital re-admission, improve health outcomes, improve the efficiency of care, reduce the cost of health care services, and achieve patient satisfaction. (January 2012)
- The **role of the Medicaid and CHIP Payment and Access Commission is expanded** to include assessments of adult services including those dually eligible and \$11 million of additional funds appropriated.

- **Increase Medicaid payments for primary care physicians** (family medicine, general internal or pediatric) to 100% of Medicare payment rates for (2013 & 2014); 100% federally funded.
- **Establish a grant program to support the delivery of evidence based and community based prevention and wellness services** designed to strengthen prevention, reduce chronic disease and address health disparities especially in rural and frontier areas. Funds appropriated 5 years starting. (2010)
- **Provide incentives to Medicare and Medicaid beneficiaries if they complete behavior modification programs** (January 2011) or when program criteria is developed whichever is first).
- **Require preventive care to be covered in Medicaid and private plans without cost sharing.** (2010)
- **Permit employers to offer employees rewards in the form of premium discounts, waivers of cost sharing up to 30% of the cost of coverage.**
- **Establish 10 state pilot programs** by (July 2014) to permit participating states to apply similar rewards for participating in wellness programs in the individual market.



## **VIII Implement Federal Health Reform**

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### **Background**

In March 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Affordability Reconciliation Act of 2010, legislation that makes major changes to the nation's health care system. National health care reform aspires to universal coverage, improved health care quality, strengthened public health and prevention, and cost containment by promoting shared responsibility among individuals, government, employers, health care providers, and insurers. Key elements include:

- An individual insurance mandate that requires individuals and families to purchase insurance if it is affordable for them;
- Expansion of the Medicaid program to all citizens and qualifying immigrants earning up to 133% of the federal poverty level (FPL) and federal tax credits to provide insurance subsidies for low- and middle-income earners up to 400% FPL;
- Requirements that larger employers provide coverage or pay an assessment; incentives for small businesses to provide coverage to their employees;
- Cuts in the growth of Medicare payments to providers and new incentives to promote health care quality, care-coordination, and preventive care;
- Changes in insurance market rules that allow more people to buy and retain private coverage;
- Payment reform incentives and pilots favoring primary care, medical home and global payments;
- Opportunities to improve access to primary care by expanding the number of primary health care settings and the primary health care workforce;
- New taxes on certain health sector business, high-income families, and high-cost health plans; and
- Support for states to improve public health, prevention and health care quality.

While the federal government, through the PPACA, retains control of the implementation of many of the public health and quality initiatives included in the law, national reform relies on states to carry out and monitor many of the major changes, particularly regarding the Medicaid expansion; new insurance market rules; promotion of quality, service delivery and payment reforms; and creating state-level insurance markets called Exchanges. State insurance regulators and the National Association of Insurance Commissioners (NAIC) have been given a significant role in the development of the new federal standards, as well as their implementation and enforcement.

Maine has a long history of health reform and is well positioned to implement the PPACA. Specifically, Maine has been a leader in expanding access to the uninsured through insurance reforms, Medicaid expansions and the enactment of Dirigo Health reform in 2003. In 2009, Maine was one of 13 states to be awarded a State Health Access Program grant from the US

Health Resources and Services Administration. This grant, renewable until 2014, provides funding to develop a voucher program, offered through the Dirigo Health Agency, to uninsured lower income part-time and direct care workers who have access to employer coverage but cannot afford it. Multiple insurance companies will participate in the voucher program and Dirigo will function like an exchange, connecting eligible workers to a variety of affordable health insurance products. Because the SHAP program is a limited 5-year demonstration, a condition of the grant was to develop a plan to ensure sustainability of coverage when grant funds end. The enactment of federal health reform provides just such an opportunity to sustain our coverage initiatives. Using our HRSA grant funds, Maine is able to quickly develop this health care reform implementation plan to implement health reform in Maine and assure that people now covered by various Dirigo access initiatives will continue to have sustainable coverage when national reform is fully implemented.

State reforms instituted in 2003 have improved Maine's uninsured rate to the sixth best in the nation in 2009 (up from 19<sup>th</sup> in 2003) and the state population's health status to thirteenth best in the nation in 2009 (up from 25<sup>th</sup> in 2003). Through the state Medicaid and Children's Health Insurance Program (CHIP), Maine currently provides generous publicly funded health benefits. MaineCare already covers childless adults, a group not ordinarily eligible, and families at income levels above the federally required minimum. In addition to dramatically improving health care access since 2003, Maine has developed significant health system infrastructure to support reform. Specifically:

- Multiple state agencies and legislative committees are dedicated to overseeing the state's health care system and driving innovation;
- Prior state-level reforms place Maine ahead of the coverage curve and align the state's insurance market regulations with the new federal rules;
- Maine's commitment to quality measurement and data reporting give the state a head start on federal reforms and provide a good foundation on which to build future efforts;
- Newly established public health infrastructure and innovative initiatives such as Keep Me Well and the Wellness Council can be leveraged to further advance individual and employee health programs under federal reform;
- The state already administers health care tax credits, insurance subsidies, a large employer insurance voucher program, and a consumer-focused website through the Dirigo Health Agency; and
- A MaineCare managed care initiative, consistent with PPACA principles, is in the planning stages.

## **Financing federal reform**

The federal health reform law dedicates more than nine-hundred billion dollars over ten years to expand insurance coverage, implement new insurance rules and Exchanges, and support delivery system change. These costs are offset by savings in the Medicare and Medicaid programs and by new taxes on individuals and businesses. The Congressional Budget Office estimates that national health care reform will reduce the federal deficit by \$124 billion over ten years. New federal spending for Medicaid and CHIP, in the form of an increase in the rate at which the federal government matches state spending, and for insurance subsidies to help low- and moderate-income people afford coverage, will directly affect Maine's state spending on health coverage for its residents. Federal insurance subsidies for small businesses will also be available to urge small employers to offer coverage. About 37,000 small businesses in Maine could benefit.

### ***Revenue Provisions***

Funding for federal health care reform comes in part from several new taxes and assessments on businesses and individuals, and in part from spending reductions, in Medicare, largely by eliminating subsidies provided to insurance companies that run Medicare Advantage plans. Some policy experts predict that new quality, care-coordination, payment reform and service delivery changes will produce additional savings for the government and other payers, but the Congressional Budget Office did not account for most of these initiatives in its cost estimates because their implementation and impact are not yet clear.

Medicare savings come from reductions in the growth in Medicare provider rates and the introduction of a productivity adjustment, which will advantage some providers and disadvantage others. The law restructures the Medicare Advantage program and reduces Disproportionate Share Hospital (DSH) payments under the Medicare program. The law also increases the rebate drug manufacturers pay to state Medicaid programs, with the incremental proceeds (and, in Maine's case, some additional rebate funds as well) going to the federal government and reduced rebate revenues for states.

Revenue will also be generated through new taxes and fees on high-income earners and on certain health sector businesses such as pharmaceutical and medical device companies. The law levies taxes on health insurers, including an excise tax on high cost health plans that will phase in beginning in 2018. Individuals who earn more than \$200,000 per year and couples who earn more than \$250,000—between 1.5% and 1.9% of Maine taxpayers—will face a 0.9% increase in the Medicare payroll tax on income over that threshold and will owe a 3.8% tax on unearned income such as rents, investments, and dividends.

## **Maine's role in implementing federal reform**

The federal government will provide significant support for states to implement health care reform, but state action and new expenditures will be required in some key areas. Implementing the health reform law will require significant attention and activity by both the Executive and Legislative branches of government in Maine over the next several years. This state health plan chapter frames the most urgent policy issues and tasks identified to date. As the federal government begins to release draft regulations and shape the features included in the PPACA, new policy issues undoubtedly will arise. As described further below, Maine has put in place a structure within the Executive Branch through its Health Reform Steering Committee and its Advisory Council on Health System Development to implement health reform in a thoughtful and transparent manner. Further, the Legislature has also established the Joint Select Committee on Health Reform. These structures will allow for both the Governor and the Legislature to be well informed of the implications of the health reform law in Maine and to receive comprehensive policy options, analysis and recommendations.

Policymakers in Maine will face the following major policy questions in 2010 and beyond:

1. Will Maine establish a state health insurance Exchange that meets the federal requirements while serving the needs of the individuals, families, and businesses that use this marketplace or allow the federal government to do so? If Maine elects to run an exchange, how will it do so?
2. Whether Dirigo assessment on businesses will be needed and if so, how will it be utilized going forward?
3. Will Maine enforce the insurance market reforms, or allow federal regulators to assume these responsibilities?
4. What strategic opportunities can the Maine Medicaid program (MaineCare) take advantage of under the PPACA? How will the eligibility expansions, payment rules and benefit requirements impact the current program?
5. How will Maine coordinate its system for public program eligibility determinations with the exchange given the new federal requirements?
6. What criteria and priorities will guide Maine's pursuit of grants, demonstration projects, and payment reform pilot programs offered through the PPACA?

The state faces numerous other choices about whether to take action on specific policy matters throughout the implementation process during the coming years. These opportunities range from promoting workforce development and wellness and public health and prevention programs to beginning the process of reforming the payment system and implementing innovative care delivery models. While Maine has a responsibility to take some actions due to new federal requirements, the state also has a wonderful opportunity to pursue its own path for reform given the flexibility provided under the PPACA.

This chapter highlights the major policy options delineated above and provides a detailed list of key activities that the state should consider as implementation moves forward in 2010 and beyond. This planning document will serve as a framework – a key document in the

implementation of health reform, but identified state agencies will develop their own health reform work plans to direct specific activities identified here that fall within their responsibilities.

## **Major Policy Options**

Maine will need to consider a number of policy options throughout the implementation of the PPACA. This section presents five core areas where significant decision-making will need to occur in the short-term: 1) Exchange governance and infrastructure, 2) Dirigo assessments, 3) insurance reforms, 4) expansion of publicly funded coverage, and 5) payment and system reform and related funding opportunities. Other areas for consideration are presented in the Key Activities section below; as implementation activities begin it is possible that other planning questions will rise to the level of a major policy option.

### **Exchange**

Maine already conducts many of the functions envisioned in an exchange in the Dirigo program. There are several first-order decisions that state policymakers must consider regarding the governance and structure of an exchange. The first is whether Maine will accept responsibility for administering its own exchange. The PPACA provides states with an option to develop and manage their own exchange or to default to the federal government to operate the exchange.

#### ***Operating an Exchange***

States accepting responsibility for the exchange must establish an American Health Benefit Exchange to serve individuals who receive tax credits as well as others who are purchasing insurance on their own. The law also requires states to establish a Small Business Health Option Programs (SHOP) for employers with fewer than 100 employees. States can opt to operate both of these pooling entities under a single exchange. Unless state policymakers choose to have the federal government regulate insurance in Maine, the Bureau of Insurance would be responsible for reviewing and approving the policy terms and premium rates for the insurance products and regulating the market conduct and financial condition of the insurers offering coverage through the exchange, as it does for other insurance products.

In considering whether to operate an exchange or to default to the federal government, there are a number of issues to consider, including:

- Coordination with other health coverage programs
- Capacity
- Flexibility
- Efficiency
- Uniqueness of market characteristics

It would be advantageous for states to manage their own exchanges for several reasons. It would likely be less complex to coordinate benefits and eligibility across all state programs if the exchange operates in-state. Additionally, although federal standards for the state-level exchanges will be determined, it may be desirable to customize an exchange to best meet the

needs of a state's residents. Relinquishing this responsibility to the federal government would likely create more work for agencies required to coordinate with the exchange and may not provide enough flexibility regarding implementation issues that arise.

### ***Potential for Development of a Regional Exchange***

Another important decision is whether Maine should establish or join a regional exchange. As with the initial question of whether Maine should administer an exchange at all, considerations include coordination, capacity, flexibility, efficiency and how similar the market characteristics (including demographics of those who will be purchasing through the exchange, number and type of carriers and plans, employer offer rates, etc.).

The advantages of a regional exchange include some economies of scale, in addition to some added portability that could result from having product availability across contiguous states. However, given the ambitious federal timelines, challenges of working across states with multiple state agencies and Maine's differing provider and insurance carrier profiles compared with neighboring states (NH, VT and MA) it is unlikely that a regional exchange would be initially desirable. In addition, federal start-up funds will be available to states and Maine should take advantage of this opportunity initially to build the needed infrastructure—including effective and seamless eligibility systems—for the overall reform activities. This option would not preclude some regionalization of certain aspects of the exchange such as data sharing and opportunities for regional demonstration projects or grants.

### ***Who Administers the Exchange***

If Maine decides to implement its own exchange, subsequent choices arise such as whether the state should establish one or more exchanges and where to house the exchange(s). Maine will want to consider its population demographics, carrier market share, provider networks, capacity and resource requirements to determine whether one or more exchanges are warranted. In addition, estimates of the numbers of individuals and businesses expected to enroll in an exchange is important when considering whether to establish one or more exchanges. Whether to establish a new entity or build upon current state infrastructure is the next question that Maine faces. The exchange needs the capacity to accomplish an extensive list of tasks—including (but not limited to) processing applications, confirming eligibility for tax credits, billing premiums, monitoring employer contributions, reconciling payments, developing and maintaining a website, payment of commissions, ongoing marketing and outreach, and developing and maintaining an electronic interface.

The exchange could be housed in a governmental agency. Housing the exchange in a non-profit organization could be perceived by some to be more agile and business-friendly, particularly for the SHOP exchange, but it also further removes the state from important and time-sensitive decision-making. Two separate exchanges would duplicate functions and could lead to added complexity and confusion for consumers. Moreover, Massachusetts experience of fewer than expected small businesses purchasing through its exchange, may make it unlikely that an entirely new organization focused only on small businesses would be large enough to justify its start-up and on-going operational costs.

Creating a new state agency to house the exchange may be viewed as redundant since so much of the functionality already exists within another state entity. It would also create additional administrative burdens for carriers and others who will be required to report to and/or work with a growing number of state agencies. Another disadvantage is for recipients of benefits who may endure issues with continuity of coverage because of lack of coordination among the various agencies.

Regardless of where it sits, the exchange will require significant interface with other state agencies including, at a minimum, our Medicaid agency, the Bureau of Insurance and Maine Revenue Services.<sup>9</sup> In addition, Maine will want to evaluate the capabilities of organizations that play an intermediary role in our state to determine whether they have some of the needed capabilities to operate various functions of the exchange through a sub-contract.<sup>10</sup> These decisions will be critical in the short-term to meet federal deadlines for establishing the exchange.

### ***Funding to Support Development of the Exchange***

One of the many funding opportunities included within the PPACA is federal support to states for the development of the exchange. These federal funds become available within one year of the bill's enactment and continue through January 2015. The Governor's Office of Health Policy and Finance should submit an application for such funding, when it becomes available. This opportunity will allow the state to conduct detailed analysis on the advantages and disadvantages of operating its own exchange, joining a regional exchange or defaulting to the federally-run exchange by the required notification date to HHS of their intention to operate an exchange by January 1, 2013.

### ***Eligibility Determinations***

The PPACA requires streamlined eligibility across the Medicaid, CHIP and subsidy programs, providing a seamless point of entry common to Medicaid and subsidized insurance. This will require information system development likely subsidized by CMS.

Specifically, the law directs the U.S. Department of Health and Human Services to establish a system that offers a single application for Medicaid, CHIP, and federal subsidies.<sup>11</sup> Further, the law requires applicants to have the option to apply for benefits and subsidies through a website that provides a comparison of available benefits across plans participating in the Medicaid program and the exchange. The federal law requires that Medicaid and CHIP programs accept eligibility determinations made by the exchange without any further determination. Likewise,

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<sup>9</sup> Maine Revenue Services is likely to be involved in assisting the exchange in verifying individual and small business eligibility for subsidies based on individual income and employer size.

<sup>10</sup> For example, in Massachusetts the exchange subcontracts with an intermediary to provide sophisticated information technology needs without having to duplicate effort.

<sup>11</sup> The PPACA provides states with the option to develop a Basic Health Plan for individuals between 133-200% of the FPL. If Maine opts to develop such an option, eligibility for the Basic Health Plan must also be included in this streamlining effort.

the exchange must accept eligibility determinations for subsidies made through Medicaid and CHIP.

Today, the Dirigo Health Agency operates eligibility functions for subsidies and vouchers. The Maine Department of Health and Human Services (DHHS) operates an integrated eligibility system that performs eligibility functions for 26 public assistance programs, including MaineCare, Cub Care (CHIP) and Maine's prescription drug programs, and also including TANF and the Supplemental Nutrition Assistance Program. This integrated eligibility system provides streamlined "one-stop" access to services for Maine citizens that is not available in most states. DHHS is in the process of developing a web portal to its integrated eligibility system that will provide an electronic option for eligibility determinations, enrollments and recertifications.

Specific policy questions to be answered include:

- Will the current web-portal activity being undertaken by DHHS accommodate the requirements under the PPACA that requires streamlined, on-line eligibility for subsidies and/or MaineCare be accessible to all?
- Will the web-portal serve as the only entry into the system or will there be other methods for eligibility applications to be accepted (e.g., provide for a "no wrong door approach")
- What modifications need to be made to the state's current eligibility system to provide for streamlined eligibility? What resources are needed? How long will such system modifications take to make?

In addition to deciding where eligibility determinations are made, Maine will also need to analyze its current determination of eligibility to meet the new federal requirement that eligibility be based on modified gross income for nonelderly applicants. The PPACA provides a specific definition of Modified Adjusted Gross Income, including an across the board 5% income disregard, and prohibits states from utilizing any other income disregards when determining eligibility, premiums and cost-sharing.

### ***Longer Term Decisions***

In the longer term, the state will have the opportunity to consider the impact of the exchange on health coverage generally and the insurance market specifically. First, in 2017, Maine will have the opportunity to consider seeking a five-year waiver from the federal government permitting the state to opt out of certain new health insurance requirements if the state is able to demonstrate that it provides universal coverage that is as comprehensive as the coverage required under an exchange plan and that such a waiver would not increase the federal budget deficit. Assuming the state determines it would like to maintain the federal health reform construct, the state also may want to consider whether the exchange should become the state's insurance market or whether the state should continue to have a market outside of the exchange.

Many of the first-order policy decisions outlined above should occur within a 6-month time frame. Maine will want to well prepare itself to respond to the federal government regarding start-up exchange funds and seek to influence implementation decisions at the federal level.



Once the high-level decisions are made, Maine can begin to contemplate the myriad of smaller policy decisions inherent in getting the exchange up and running.

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**Goal VIII.1: To assure timely, effective and transparent implementation of PPACA in Maine**

**Task 1:** The Health Care Reform Implementation Steering Committee will develop option papers, with guidance from ACHSD, identifying and analyzing policy options to provide recommendations for the Governor and Legislature.

### Decision Points – Exchange

<u>Date</u>	<u>Action</u>
By 12/31/10	Decision to create exchange, and whether one exchange or two
	Decision on where exchange should be housed
	Form planning group to develop exchange; create work plan
By 6/30/11	Secure federal planning funds
By 1/30/12	Begin efforts to modify state eligibility systems, as needed to comply with federal law
By 1/1/13	Enact legislation creating exchange
1/1/14	Launch exchange

## Dirigo and the Federal Financing of Reform

A central feature of the PPACA is the additional federal funding that will be available to support expansions in MaineCare coverage and to subsidize the purchase of private insurance for low- and moderate-income people not eligible for public coverage. The new federal dollars will supplant state subsidies available through DirigoChoice, and thus raise important policy questions about Dirigo's existing funding mechanism.

### *Dirigo Financing*

DirigoChoice provides subsidized health insurance premiums on a sliding scale for individuals and families with incomes up to 300 percent of the Federal Poverty Level (FPL).<sup>12</sup> The Dirigo subsidies are funded by a 2.14 percent assessment on claims paid by Maine health insurers and by third party administrators who run self-insured plans. The assessment is expected to generate \$42.1 million in State Fiscal Year 2010.

### *New Federal Subsidies*

Beginning in 2014, federal tax credits will subsidize the purchase of health insurance through the Exchange for individuals and families with incomes between 133 percent and 400 percent FPL. The credits are structured so that people at the low end of this range would be responsible for paying 2 percent of their income toward a premium; at the upper end, 9.5 percent. There are also

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<sup>12</sup> The 2010 federal poverty level for an individual is \$10,830 and \$18,312 for a family of three.

subsidies available to help people up to 250 percent FPL to pay their deductibles and copayments. Most people with incomes less than 133 percent FPL<sup>13</sup> will be eligible for Medicaid, with enhanced Federal funding.

All current DirigoChoice enrollees will be eligible for the new federal tax credits. In fact, eligibility for the federal credit extends beyond the eligibility limit of 300 percent FPL for Dirigo subsidies, to 400 percent FPL. As further described in the Coverage Expansion section below, it is also possible for Maine to shift some members with incomes between 133 percent and 200 percent FPL who are currently enrolled in MaineCare into a basic health plan in the Exchange to leverage more federal dollars or simply to transition them to coverage in the exchange.

Because the federal revenues for premium and cost sharing tax credits will replace state spending for DirigoChoice subsidies, the assessment dollars now collected from health plans will no longer be needed for subsidies. However, a portion of the assessment currently is utilized to fund statewide quality initiatives through Dirigo's Maine Health Quality Forum and the need for such funds remains. Maine may consider options for future assessments as follows:

- **Repeal the assessment beginning in 2014.** No longer collect an assessment on health insurance claims. In repealing the assessment, the state could require health insurers to apply the savings to reduce health insurance premiums. In repealing the assessment, Maine will need to consider what funds will be available to continue to fund statewide quality initiatives.
- **Retain assessment – either at the current level or a reduced rate.** The assessment on health claims provides significant funds to support Maine's current health care system. Despite the influx of new federal dollars into Maine, there will undoubtedly be gaps in funding that the state may want to consider. For example, Health InfoNet, Maine's electronic health exchange needs sustainable funding, although would require only a small percentage of the current assessment. HIN has the potential to yield a positive return on investment through the improved efficiency of medical care, reduced medical errors, and lower cost. Some may be used to continue to fund the work of the Maine Quality Forum. Both initiatives could be conducted with a reduced assessment level
- **Supplementing the federal subsidy to improve benefits.** The federal premium tax credit is tied to the value of a specific benefit plan which has not yet been defined.<sup>14</sup> While the federal plan must include preventive care and pediatric services, it is possible that the federally-specified benefits will not be as extensive as the benefits available in Maine today. To the extent that Maine currently has insurance mandates that are not included in the federal plan, or desires a richer (and so more costly) benefit package for

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<sup>13</sup> The federal law builds in a standard 5% of income disregard into the gross income test, making the actual income level for eligibility 138% of the FPL.

<sup>14</sup> The federal law requires HHS to define four benefit categories to be provided through an exchange. The basic plan, for which subsidies will be available, must provide minimum essential coverage at the actuarial value of 60% while the highest plan will require an actuarial value of 90%.

individuals and families purchasing coverage through the Exchange, some of the assessment might go toward supplementing the federal subsidy so that enrollees would not pay a larger share of their income than the federal law requires.

- **State subsidy to maximize coverage.** Some Mainers will be exempted from the requirement to have insurance because available options are too expensive given their family income levels. Assessment funds could be used for a state subsidy to help those who do not qualify for the federal tax credit to afford coverage

Prior to the start of the federal tax subsidies in 2014, Maine will undertake a detailed analysis of these and other options to determine the disposition of the Dirigo assessment.

### ***Public Option***

The PPACA permits states to develop a Basic Health Program for individuals with incomes between 133-200 percent of the FPL instead of providing such individuals with subsidies to purchase health insurance. However, these individuals and all those below 400 percent of poverty would be eligible for subsidies in the Exchange and creating a Basic Health Plan would establish another program and may cause confusion. The state may consider whether it is interested in establishing a Basic Health Program and what would be entailed to meet federal requirements. A notable feature is that the PPACA restricts the funds available for a Basic Health Program to 85 percent of the premium and cost sharing subsidies that enrollees would have received if they were enrolled in a health plan through the Exchange. Under the PPACA, the Basic Health Program would become effective in January 2014 at the same time as the exchange.

**Task 2:** The Health Care Reform Implementation Steering Committee will develop option papers, with guidance from ACHSD, identifying and analyzing policy options to provide recommendations for the Governor and Legislature.

#### **Decision Points – Dirigo and Federal Financing**

Date	Action
By 12/31/10	Develop list of options for disposition of Dirigo assessment
	Analyze cost and feasibility of assessment options
	Decision on whether to develop Basic Health Program
By 12/31/11	Decision on disposition of Dirigo assessment
By 6/30/13	Enact legislation to change Dirigo assessment Enact legislation to create Basic Health Plan, if appropriate
1/1/14	Changes to Dirigo assessment in effect Launch Basic Health Program, if applicable

## **Insurance Reform**

Although federal reforms include many of the types of insurance market reforms Maine has already implemented, it will be important to review Maine's laws to ensure that they meet the minimum federal standards. PPACA (similar to earlier federal HIPAA reforms) largely relies on state insurance regulators to monitor compliance. If a state is unable or unwilling, then federal regulators are allowed to come into a state and take over regulation to ensure compliance with national standards.

A key decision for Maine's policymakers will be whether to modify Maine's laws to ensure that the state's laws meet the minimum standards set out in federal law. Generally, state insurance regulators can only enforce state insurance laws, not federal laws. Absent modifications to state insurance law, federal enforcement would be necessary.

In addition, PPACA recognizes that insurance markets vary and that states have chosen a variety of ways to protect consumers. PPACA preserves the right of states to continue to do that. Because federal law sets a minimum standard, states have flexibility and can have and enact other laws and additional consumer protections.

Some key policy decisions that Maine will need to make immediately and before 2014 regarding the insurance market include:

- Whether to expand the definition of the small group market to include businesses with up to 100 employees
- Whether to merge the small group and individual markets

- How to participate in the development of national standards, directly and through the NAIC
- Whether to take an active role in enforcing the insurance market reforms, or allow federal regulators to assume these responsibilities
- What revisions to make to Maine's insurance laws to meet the minimum federal requirements, including medical loss ratio standards, rate review, and a variety of other consumer protection standards
- Whether to maintain or reduce the state's mandated insurance benefit requirements
- Whether to participate in interstate insurance compacts, beginning in 2016, that would allow for the sale of insurance products across state lines

### ***Individual and Small Group Markets***

One of the important considerations in this arena is whether to merge the non-group and small group markets. The Blue Ribbon Commission on Dirigo studied this issue and determined that while there are several advantages to a merger, a merged market was likely to cause an increase in premiums in the small group market under current market conditions. The Commission made recommendations to merge the market if the financial impact on small businesses can be mitigated. The extension of the small group market to firms with 100 employees or fewer (up from 50 or fewer), coupled with the individual mandate, substantial financial subsidies to individuals and employer incentives, may provide enough of a buffer against increased risk to merge the markets as desired without causing an increase in small group premiums.

Maine will need to consider the advantages and disadvantages of merging these markets in a reformed environment. PPACA also increases the threshold for large employer status from 50 to 100, effective in 2014, but allows states to opt out during 2014 and 2015. Maine will have to decide whether to allow the expansion to take effect immediately or postpone implementation.

### ***Medical Loss Ratio***

As Maine does today, the PPACA requires health insurance plans to report medical loss ratios. Under the PPACA there is a minimum MLR of 85 percent in the large group market and 80 percent in the individual and small group market. Maine does not now regulate large group rates, and there are significant differences between Maine's current MLR requirements and the federal definitions. These inconsistencies will need to be examined and the state will likely need to amend its laws to comply with the minimum MLR allowable to be consistent with the federal law.

In addition to considering the minimum MLR, Maine will also need to consider how its current definition of MLR compares to the final regulation to be issued by the federal Department of Health and Human Services (HHS). The language used in the PPACA, which is the subject of a request for comments by HHS, is different from the definitions used in Maine and other states. This makes the comparison between current Maine requirements and the new federal requirements more complex. In addition, the regulations call for the issuance of partial premium

rebates to consumers whose plans have MLRs that fail to meet federal standards. Maine currently requires premium rebates on a pro rata basis. The state may need to modify its process for monitoring a health insurer's premium rebates depending on the language of the upcoming federal regulations

### ***Rate Review***

The PPACA establishes a process for reviewing the reasonableness of health insurance premiums. While Maine already reviews and approves premium rates set by insurers in the non-group market, small group premium prices are not subject to prior approval as long as the insurer agrees to issue coverage on a guaranteed MLR basis. For guaranteed MLR products, rates are reviewed but not subject to prior approval. Large group market rates are filed for informational purposes.

Maine should consider whether there are further actions that could be taken by the Superintendent of Insurance to review rates and whether the state may qualify for grant funds to review health insurance increases. These funds become available in 2010.

### ***Consumer Protection and Rating Standards***

The PPACA establishes new federal minimum standards in a number of areas, including but not limited to protections for consumers with health conditions, expansion of dependent coverage, transparency in health insurance documents and communications, appeal processes, and limits on variations in premium rates. Although Maine law equals or exceeds federal requirements in many areas, other federal requirements are new, or are structured differently from their Maine counterparts.

Maine needs to evaluate its insurance laws and to make changes as appropriate. If states do not enforce the federal requirements, HHS is given the authority to step in.

### ***State Mandates***

The PPACA requires states to evaluate the cost of their state insurance mandates that are not included in the essential benefit plan that will be determined through federal regulation. Any person receiving federal tax credits for insurance through the exchange will not be credited for benefits above this basic benefit plan.

Once the regulations are promulgated for the essential benefit plan, Maine will need to determine whether or not it wants to fund any additional mandates through a state-only revenue source, such as the Dirigo assessment.

### ***Interstate Insurance Compacts***

The PPACA allows states, on a voluntary basis, to form "health care choice compacts" that allow insurers to sell policies in any state participating in the compact. As a starting point, Maine will need to determine whether it is interested in forming or joining a compact, and, if so, which states would likely be partners. Choice of state partners is a key decision as, under the federal

law, an insurer is required to follow some but not all state insurance laws by each of the states participating in the compact. The insurer is only required to follow all the state insurance laws for the state in which the insurer is domiciled. For example, if Maine has stronger consumer protection laws than some of its state partners, Maine residents that purchase through the compact may not receive those same protections as Maine's insurance regulators may not be able to fully enforce Maine's laws. Federal regulations for interstate compacts will not be issued until 2013; with compacts beginning operations in 2016.

**Task 3:** The Health Care Reform Implementation Steering Committee will develop option papers, with guidance from ACHSD, identifying and analyzing policy options to provide recommendations for the Governor and Legislature.

#### **Decision Points – Insurance Reform**

Date	Action
ongoing	Work with NAIC and HHS on development of federal insurance standards
By 9/30/10	Review Insurance Code provisions and Bureau of Insurance rules for consistency with federal requirements
By 12/31/10	Decision on whether to increase small group to firms with 100 employees; merge small and non-group markets
By 12/31/10	Apply for grant funding to review health insurance provisions, when available
By 12/31/11	Decision on whether to fund state insurance mandates in excess of federal mandates using state dollars
By 12/31/13	Decision on interest in forming an interstate insurance compact

### **Expansion of Publicly Funded Benefits**

Maine is ahead of most states in its use of MaineCare to cover low income people.<sup>15</sup> The PPACA provides for expansion of public programs through a combination of expanded Medicaid eligibility, enhanced federal match for Medicaid and CHIP, and the development of a subsidy program for the purchase of private insurance through an exchange for individuals with incomes up to 400 percent of the federal poverty level (FPL).<sup>16</sup> At the same time, the PPACA modifies the current prescription drug rebate policy in a way that reduces Maine's revenue by retaining a greater level of savings from prescription drug rebates for the federal government.

<sup>15</sup> Today, MaineCare covers children to 200% of the FPL through a combination of Medicaid and CHIP; parents to 200% of the FPL; and pregnant women to 185% of the FPL. MaineCare also covers disabled individuals at varying income levels depending on whether income is earned and unearned.

<sup>16</sup> The 2010 federal poverty level for an individual is \$10,830 and \$18,312 for a family of three.

Specifically, the PPACA expands eligibility for Medicaid to all individuals under the age of 65 to 133 percent of the FPL beginning in 2014. Enhanced Medicaid federal match rates will offset state funding for childless adults with incomes less than 100 percent FPL who now have coverage under MaineCare. Maine will also receive enhanced federal funding beginning in 2014 to cover childless adults earning between 100 percent FPL and 133 percent FPL, as well as those under 100 percent FPL who are on the program's waiting list. Because Maine previously provided coverage to some of the new mandatory categories, Maine is considered an expansion state under the federal law. As an expansion state, federal dollars will fully support the expansion of individuals between 100 and 133 percent of the FPL for the first three years, but Maine will be required to contribute a small percentage of this population's coverage costs beginning in 2017 (the state share increases each subsequent year and settles at 10 percent for 2020 and beyond). Maine will also receive enhanced match based on a statutory formula for those childless adults below 100 percent of the FPL who are already covered in Maine which will significantly reduce state funds required to cover these populations going forward, provided the state maintains current eligibility levels for the Medicaid and CHIP program, including for coverage of parents, pregnant women and persons with disabilities with incomes above 133 percent of FPL. Maine will also receive significant enhanced funding (23 percent points) for children covered in the state's CHIP program up to 200 percent FPL, if it elects to continue them in the CHIP program from 2014-2019. These increases only take effect if the state maintains current eligibility levels for the Medicaid and CHIP program.

The PPACA also creates a new mandatory categorical eligibility for former foster care children, regardless of income, until the age of 26. This section is effective on January 1, 2014.

While the expansions do not become mandatory until 2014, it is essential to immediately conduct analysis of the increases and decreases in federal revenue through the federal law and the long-term impact on required state-funding for these expanded benefits. Once the analysis is complete, Maine has a number of options to quickly consider including:

- Whether to allow childless adults into MaineCare prior to 2014 (at regular match), including potential movement of individuals currently in DirigoChoice and outright expansion
- Will the state be required to proactively identify former foster children for enrollment in Medicaid if they are under age 26 but have already aged out of the foster care system
- Assess whether Maine will have a budget deficit between January 1, 2011 and December 31, 2013, and if so, whether Maine will consider reducing eligibility for non-pregnant, non-disabled parents to 133 percent of the FPL.



**Task 4:** The Health Care Reform Implementation Steering Committee will develop option papers, with guidance from ACHSD, identifying and analyzing policy options to provide recommendations for the Governor and Legislature.

#### Decision Points - Expansion

Date	Action
12/31/10	Conduct financial analysis of impact of expanding to childless adults prior to 2014
	Determine additional state dollars for such expansion
	Make decision on whether to expand prior to 2014
7/1/13	Determine how will identify former foster children to enroll in Medicaid program
7/1/10; 7/1/13	If budget deficit, determine whether will consider reducing eligibility as maintenance of effort requirement will be waived

### System and Payment Reform

Fundamental system reform that addresses public health, prevention and wellness, and how necessary health care is provided, paid for and monitored is a key focus of the PPACA. Maine is host to a large number of initiatives, both public and private, to improve the health of Mainers and the ways they receive and pay for health care. The Maine Wellness Council and the Healthy Maine Partnerships are examples of collaborations that improve the health and wellbeing of people who live and work in Maine. Dirigo's Maine Quality Forum leads efforts to improve the quality and safety of health care.

Payment reform efforts are described in detail in Chapter VI. Several payment reform initiatives are underway with state employees and the private sector, including the Maine Health Management Coalition's payment reform planning process for the state's largest employers and an initiative is underway with CIGNA, Bath Iron Works and providers. A 26 site patient centered medial home demonstration is also underway. The Legislature has tasked the Advisory Council on Health Systems Development to report back in January, 2011 with recommendations for action based on the models mentioned above.

The initiative that Maine's government, nonprofits, and businesses have taken to improve health care may put the state in a good position to take advantage of new opportunities in the health reform law. The PPACA takes a decentralized approach to promote payment and delivery system reform, through funding for demonstration projects, pilot programs, and grants targeted to states, municipalities, medical schools, hospitals, nursing homes, and other providers. Many of these projects focus on areas that have been a priority for Maine, including these examples (among many others):

- **Preventive Care:** Grants for medical schools to provide preventive care training for medical residents; support for non-profits, community-based organizations, and

governments to promote evidenced-based preventive health activities in local communities.

- **Wellness:** Funding for a wellness program demonstration and a preventive benefits outreach campaign; incentives to prevent chronic diseases in Medicaid
- **Quality:** Grants to institutions to adapt and implement models and practices that promote evidence-based quality and reductions in health disparities, and to states to develop quality measures and establish community health teams to support patient-centered medical homes
- **Expansion of Primary Care Health Care Settings and Workforce:** State health care workforce development grants, workforce diversity grants, and demonstrations to address health professions workforce needs
- **Payment reform:** Funding for demonstrations on global and bundled payments and pediatric accountable care organizations, planning grants for creating medical homes for people with chronic illness. Funding provides key opportunity for public purchasers, including Medicaid and Medicare, to lead or participate in multi-payor payment reform efforts.
- **Medical Malpractice Demonstration:** Funding available for development for an alternative medical malpractice system

Maine will need to review all of the relevant opportunities in the law, quickly prioritize them and develop relationships with researchers and others in order to best meet the state's goals for improved quality and system reform. As appropriate, the payment and system reform initiatives will be integrated into the Medicaid Managed Care initiative currently in the planning stages. Because each of these grants opportunities will be of interest to various stakeholder groups, there will be pressure on the state to apply for as many as possible. However, given the fact that most of these grants require some level of state matching funds or resource commitment and that the state has finite resources to implement, manage and monitor available opportunities, the Health Care Reform Implementation Steering Committee should develop a recommended set of criteria, with input from the Advisory Council on Health System Development, to follow in considering the application or support of such grants. Examples of appropriate criteria include:

- Priority in the State Health Plan
- Related initiatives underway in Maine
- Broad coalition of support
- Level of state funding required (lower is better)

In addition to developing a prioritization for grants that require the state to act as a lead, it is also important for Maine to develop an overall workforce development strategy to guide local organizations and health care providers on which grants are likely to be of the most benefit to Maine and support statewide priorities. These funds begin coming available in 2010.

**Task 5:** The Health Care Reform Implementation Steering Committee will develop option papers, with guidance from ACHSD, identifying and analyzing policy options to provide recommendations for the Governor and Legislature.

#### **Decision Points –System & Payment Reform**

Date	Action
8/1/10	Review all grants provided for under PPACA and group into state led and other grants
	Develop a set of criteria to use in prioritization of grants; may require different criteria for different types of grants
	Prioritize state led grants and assign responsible state agency for each grant to lead development
9/1/10	Develop a strategy for state outreach to organizations and providers around available grants and how they fit within state priorities

## **Key Activities**

Implementation of health care reform will require considerable state staff resources over the next several years. As described above, the PPACA provides states with the opportunity and responsibility to administer much of the federal reforms. Through an Executive Order issued on April 22, 2010, Governor Baldacci established a Health Reform Implementation Steering Committee chaired by the Director of the Governor's Office of Health Policy & Finance and including leaders of key agencies that will be charged with implementing the reform at the state level. All official work of the Health Reform Implementation Steering Committee will be done through public meetings. The Executive Order further identified the Advisory Council on Health Systems Development to serve as the advisory stakeholder group to advise the Steering Committee on health reform implementation.

**Task 6:** During its monthly meetings, the Advisory Council will review state agency analysis, options and recommendations regarding the major policy decisions described above and will provide its recommendations to the Governor and the Legislative Joint Select Committee on Health Reform. Over its next several meetings, the Advisory Council will take up the following major policy decisions:

- Exchange
- Payment and System Reform: Criteria for Applying for Grants
- Eligibility expansions
- Insurance Reforms
- Dirigo: Assessments going forward

Each Maine agency with responsibility to implement aspects of the health reform law shall develop a work plan including key milestones, key activities and a schedule for completion within the timeframes required under the federal law or as amended by the Legislature.

**Task 7:** Each agency will produce a work plan of all activities it must complete under the law by June 30, 2010.

**Task 8:** As Maine works to implement reform, the Health Reform Implementation Steering Committee will issue a progress report every 90 days to inform and update the Legislature, Advisory Council on Health Systems Development and other stakeholders on agency progress in implementing aspects of health reform, including, at a minimum, key decisions that have been made, key decisions remaining and policy considerations and recommendations, key tasks that have been accomplished and key tasks to be accomplished in the next 90 days. These progress reports should continue, at a minimum, through June 2014 when most of the reform activities will be implemented.

While each agency will create a detailed work plan for all of the tasks for which it is responsible, the matrix below provides an overview of key issues and activities required by the state under the health reform law, with a focus on those activities that need to be implemented in the short term.<sup>17</sup> Implementing the federal law will, at a minimum, require significant outreach and education, enactment of state legislation, development of state regulations, development of new programs and initiatives, implementation of health information technologies, and state business processes revisions. All of these activities will require input from the Legislature through its Joint Select Committee on Health Reform, the Advisory Council on Health Systems Development and other health care stakeholders.

The Table that follows describes the Key Activities and the high level to be completed. The Table also identifies the lead state agency for the high level activities and the deadlines for decisions and/or completion.

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<sup>17</sup> It is important to recognize that this matrix is not a comprehensive list of all activities that must be completed under health reform; each agency will further define additional activities to be implemented, particularly in the out years.

## Desired Outcomes

National health care reform has three primary goals: to reduce the number of individuals without health coverage; to improve the quality of health care provided; and to contain health care cost growth. The success of each of these goals is interdependent on the others.

1. Implementation of key activities on time and through efficient use of resources.
2. Increased federal support for Maine:
  - a. through enhanced federal reimbursement for health coverage for low and mid-income individuals and
  - b. through awards of grants for program development and implementation
3. Reduction in Maine's rate of uninsurance
  - a. from 9.6% in 2008 to 6% in 2012
  - b. to 3% in 2014.
4. Increased consumer-focused information on health insurance is easily accessible and available to consumers and consumer protections are in place
5. Increased health care information is available and accessible to businesses.
6. Waiting times for appointments with primary care providers are reduced by 25% by 2014.
7. Reduction in avoidable hospital admissions, emergency room admissions, and unnecessary care.
8. Increase in provider payment arrangements based on quality outcomes
9. Slower growth in health care spending
  - a. Reduced rates of health insurance premium increases
  - b. Reduced per capita spending on health care
  - c. Reduced bad debt for hospitals and other health care providers
10. Increase use of Health Information Technology by Maine health care providers

Issue	State Role	Key Tasks	Lead Agency	Legislative Role	Due Date
<b>Administrative Activities</b>					
Grant Prioritization	Maine will need to develop criteria to help prioritize efforts to obtain and support federal funding available through PPACA (whether or not state must serve as the lead)	<ul style="list-style-type: none"> <li>- Review grants and bucket into groups that delineate opportunities for states to apply for grants and opportunities for other stakeholders to apply for grants; determine which grants require state or other matching funds</li> <li>- Develop a set of criteria to assist in prioritization of grant opportunities that state will lead or support</li> <li>- Based on criteria, prioritize grants for which state must be lead</li> <li>- Assign grant development to appropriate state agencies</li> <li>- Develop a set of criteria to prioritize state support for non state-led grants</li> </ul>	Steering Committee; ACHSD	Provide state matching funds	8/10
Evaluation	Plan for evaluation of major policy changes	<ul style="list-style-type: none"> <li>- Determine with Advisory Council on Health Systems Development and the Legislature's Joint Select Committee on Health Reform how to evaluate health reform and its impact on Maine;</li> <li>- Determine which agencies and/or organizations will perform evaluation of key policies and reforms;</li> <li>- Agencies to establish measures and begin collecting baseline data.</li> </ul>	Steering Committee	Provide money for evaluation and/or authorize agencies to seek outside funding	9/10

Issue	State Role	Key Tasks	Lead Agency	Legislative Role	Due Date
Monitor Federal Activities	Review federal activities related to health reform on ongoing basis for impact on Maine activities	<ul style="list-style-type: none"> <li>- Serve as liaison to federal government and clearinghouse for federal issues</li> <li>- Review federal regulations, bulletins and other information about interpretation of PPACA provisions</li> <li>- Inform state agencies of activities</li> <li>- Coordinate Maine response to federal requests for input</li> <li>-consult with and engage appropriate state agencies</li> <li>-Consult with and engage appropriate state agencies</li> </ul>	GOHPF	Inform	Ongoing
Status Reports	Provide ongoing status reports to ACHSD and Legislature on progress in implementing health reform activities	<ul style="list-style-type: none"> <li>- Develop a template for ongoing status report to be utilized by state agencies;</li> <li>- Draft report and submit to ACHSD and Legislature every 90 days</li> </ul>	Steering Committee	Inform	Every 90 days (ongoing)
<b>Access</b>					
High Risk Pool	Monitor implementation of high risk pool	<ul style="list-style-type: none"> <li>- Monitor implementation of high risk pool (to be implemented in 8/10)</li> <li>- Consult with BOI</li> </ul>	GOHPF; Dirigo Health Agency	Inform	8/10
Reinsurance fund for retirees ages 55-64	Obtain reinsurance funds for state funded retirees	<ul style="list-style-type: none"> <li>- Apply for reinsurance funds (ASAP as funds on first come, first serve basis)</li> <li>-Analyze impact of state funds on state budget and provide Legislature with information</li> <li>- Educate private employers regarding availability of money;</li> <li>- Consult with BOI on outreach</li> </ul>	GOHPF; Dept. of Admin & Financial Services; DECD	Inform; May allow for reduced state money	9/10

Issue	State Role	Key Tasks	Lead Agency	Legislative Role	Due Date
<b>Medicaid</b>					
Medicaid drug rebate	Consider changes to the state Medicaid drug formulary	<ul style="list-style-type: none"> <li>- analyze fiscal impact of changes to federal Medicaid rebate law identify potential changes to Medicaid drug formulary;</li> <li>- analyze fiscal impact of proposed changes to state Medicaid drug formulary</li> <li>- amend state regulations or subregulatory materials</li> <li>- provide appropriate notice to beneficiaries and providers</li> </ul>	DHHS	Inform; if financial loss may require new state money	8/10
Medicaid expansion prior to 2014	Decide whether to expand eligibility for childless adults up to 133% FPL prior to availability of enhanced FMAP in 2014.	<ul style="list-style-type: none"> <li>- Conduct financial analysis of expansion prior to 2014, including determination of whether any state funds are available to fund early expansion</li> </ul>	DHHS	Statutory change required to change coverage level to 133% for childless adults; would require additional state funds	8/10
Medical provider-acquired infections	Ensure that state rules prohibiting payment for never events is inclusive of provider-acquired infections as contained in PPACA	<ul style="list-style-type: none"> <li>- Confirm that federal rules on prohibiting payment for provider-acquired infections are consistent with Maine's current rules prohibiting payment</li> <li>- Incorporate hospital acquired condition exclusion in DRG payments, consistent with Medicare DRG methodology.</li> </ul>	DHHS		1/11



Issue	State Role	Key Tasks	Lead Agency	Legislative Role	Due Date
Home and community-based services	Consider adopting federal options to enhance home and community based service state plan options	<ul style="list-style-type: none"> <li>- Analyze impact of adding state plan option for these benefits, including determination of population to be included and potential fiscal implications (both with and without enhanced federal funding)</li> <li>- Consider extent to which Maine qualifies for enhanced funding based on current balance of long term care services</li> <li>- If decide to utilize option, a number of next steps (draft state plan amendment; ensure sufficient community services; define population and extend new services; provide proper notice and rights of appeal (etc))</li> </ul>	DHHS	Would require statutory change; may require new state funds	Various dates beginning 10/10
Payment and delivery system reform	Consider applying for grants to assist with delivery system and payment reform in Maine: pilot program on Medicare payment bundling, global payment demonstration, Pediatric ACO demonstration, grants for health homes for chronically ill patients.	<ul style="list-style-type: none"> <li>- Prioritize payment and delivery system reform opportunities and develop criteria with Advisory Council on Health Systems Development to be used in deciding which grants to pursue;</li> <li>-Determine partnerships for grant opportunities</li> <li>- Consider where state can be a lead vs. play a supporting role</li> <li>- Draft or assist leads in drafting of grants and by providing letters of support</li> </ul>	GOHPF; DHHS with ACHSD	Provide letters of support as needed;	Various dates; programs begin in 9/10

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Provider payments: DSH and primary care payments in Medicaid	Project potential net effects of increased federal revenue in 2013-14 and loss of federal revenue from reduced DSH allotments; consider options for redirecting additional funds.	<ul style="list-style-type: none"> <li>- Consider impact of increased rates to Maine providers through Medicaid (both short term and when enhanced funds end</li> <li>- Consider impact on psych IMD DSH</li> <li>- Confirm that Maine is protected from DSH reductions based on waiver</li> <li>- Develop transition plan if reductions go in place when waiver period ends</li> </ul>	DHHS; GOHPF	Inform; Provide additional funds as necessary	10/11
Provider rates	Increase Medicaid rates for primary care to 100% of Medicare; 100% federal funding of incremental cost in 2013-14.	<ul style="list-style-type: none"> <li>- Determine difference b/w current rates and Medicare rates;</li> <li>- Make appropriate changes in MMIS to pay primary care providers 100% of Medicare;</li> <li>- Develop report showing difference in state developed rates and 100% of Medicare;</li> </ul> <p>Consider implications of existing PCCM, PCMH payments.</p> <ul style="list-style-type: none"> <li>- Submit claim for difference to CMS based on rules to be developed</li> </ul>	DHHS	Legislative authority to provide higher payment rate and plan for sunset of federal dollars	1/13

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Federal Medicaid expansion to 133% FPL	Expand Medicaid eligibility to 133% FPL; adjust DirigoChoice eligibility and enrollment accordingly.	<ul style="list-style-type: none"> <li>- Amend MaineCare statute and regulations to allow for increased enrollment;</li> <li>- Provide notice to individuals enrolled in Dirigo that have opportunity to move to MaineCare</li> <li>- Make eligibility systems changes (including to decision trees and notices)</li> </ul>	DHHS	Statutory change	1/14
<b>Insurance Reforms</b>					
Web-based insurance marketplace	Participate in designing federal and state websites and web-based capacity for exchange and insurance market to help consumers identify affordable coverage options.	<ul style="list-style-type: none"> <li>- Bureau of Insurance to continue to work with NAIC on input into federal website, with input from Dirigo</li> <li>- Exchange to design state specific website to provide detailed information on specific Maine coverage options in exchange</li> </ul>	Bureau of Insurance; DHA	Inform	12/10
Small business tax credits	Inform and educate small employers about the availability of tax credits to subsidize insurance coverage for employees.	<ul style="list-style-type: none"> <li>- Develop fact sheets on availability of tax credits</li> <li>- Hold forums with small businesses to help understand tax credit opportunity (ongoing through 2014)</li> </ul>	Bureau of Insurance; GOHPF; DECD	Inform	8/10 (ongoing)
Conform Maine insurance rules to new federal rules	Review and Amend Insurance Laws and Regulations to Conform with PPACA	<ul style="list-style-type: none"> <li>- Review differences in federal law and state law for all insurance changes in federal law</li> <li>- As necessary, draft legislation and regulations conforming to federal law</li> <li>- Educate insurers on new requirements, including reporting requirements</li> </ul>	Bureau of Insurance	Amend statute to conform to federal law	Various dates; begins 9/10

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Medical Loss Ratios	Insurers that fail to maintain adequate medical loss ratios will be required to provide rebates; monitor insurers to ensure compliance	- Develop a method to oversee and monitor insurers activities	Bureau of Insurance	May require amending of MLR statute	1/11
Co-Op Plans	Oversee possible development of private, non-profit, member-run Consumer Operated and Oriented Plan (CO-OP).	<ul style="list-style-type: none"> <li>- Bring together stakeholders for discussion of development of CO-OP</li> <li>- Consider pros/cons of development of such a CO-OP;</li> <li>- Consider regulatory and legislative changes necessary to allow for operation of new CO-OP</li> </ul>	Bureau of Insurance	Review statutory authority for CO-OP to operate in Maine and ensure licensing	1/13
Standardize systems for eligibility and enrollment, claims and payment	Disseminate and start to enforce standardized rules for the simplification of insurance records in the areas of eligibility/enrollment, claims/payment, encounter, and authorization.	<ul style="list-style-type: none"> <li>- Educate Maine providers and insurers on federally developed standardized rules to administratively simplify insurance records</li> <li>- Include MaineCare and worker's comp insurers to ensure consistency across all interactions with providers</li> </ul>	Bureau of Insurance; DHHS	Require insurers & Medicaid to be involved	Various dates

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Individual and employer mandates; penalties for non-compliance	Raise awareness of start of individual and employer mandates and penalties beginning 2014.	<ul style="list-style-type: none"> <li>- Determine potential mandate exemptions for individuals and employers (e.g., unaffordable coverage or provision of free choice voucher)</li> <li>- Develop fact sheets and FAQs to educate individuals and businesses about responsibilities under law</li> <li>- Consider conducting media campaign to promote enrollment to meet the mandate</li> <li>- Coordinate outreach and education activities with other ongoing outreach and education efforts</li> </ul>	GOHPF, Bureau of Insurance		1/14
New federal insurance rules and protections	<p>Implement new reforms at the state level:</p> <ul style="list-style-type: none"> <li>• Limit out-of-pocket spending below 400% FPL</li> <li>• ESI waiting period no longer than 90 days</li> <li>• Add federal-contracted multi-state plans to Exchange; Maine may want to require additional benefits (at state cost)</li> <li>• Consider merging individual and small group markets</li> </ul>	<ul style="list-style-type: none"> <li>- Evaluate existing laws for consistency with federal requirements</li> <li>- Develop regulations for insurers to comply with federal rules</li> <li>- Develop method within Exchange and MaineCare to ensure out-of-pocket maximums are tracked and complied with</li> <li>- Consider whether Maine will include state mandated benefits (at state cost)</li> <li>- Consider merging individual &amp; small group market</li> </ul>	Bureau of Insurance; State Exchange; DHHS	Statutory changes; decision on state mandated benefits & merging of individual and small group markets	Various dates; mostly 1/14

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<b>Exchange</b>					
Setting up a state Exchange	Pursue planning grant for developing Exchange and SHOP; identify state agency to house Exchange.	<ul style="list-style-type: none"> <li>- Apply for grant funds to help develop exchange</li> <li>- Work with Advisory Council on Health Systems</li> <li>- Development and Legislature to identify state agency or other nonprofit to house Exchange</li> <li>- Consult with BOI and DHHS</li> </ul>	GOHPF; DHA	Review and approval; Enact enabling legislation	12/10
Insurance subsidies for individuals, families, and businesses	Consider state tax implications of federal insurance subsidies	<ul style="list-style-type: none"> <li>- Review federal changes to determine whether cause automatic changes to state taxes</li> <li>- Based on review, identify if need to make changes to law either to extend same subsidy to state taxes or to not extend it</li> </ul>	Maine Revenue Services, GOHPF	Potential legislative change	12/10
Building a state Exchange	Begin planning structure and functions of Exchange	<ul style="list-style-type: none"> <li>- Identify key functions of Exchange</li> <li>- Determine changes to current personnel needs in transition to an Exchange</li> <li>- Work collaboratively with MaineCare on how eligibility and subsidy payment will work</li> </ul>	GOHPF, DHA	New statutory language authorizing a Exchange	10/10
State Exchange	Launch the state Exchange and begin offering minimum essential coverage to individuals and small businesses.	<ul style="list-style-type: none"> <li>- Begin operations effective Jan 1, 2014</li> <li>- Provide outreach and education of exchange offerings</li> <li>- Provide coverage for insurance with assistance of subsidies to both individuals and businesses</li> <li>- Consult with BOI and assure plans sold through the exchange comply with Maine insurance rules</li> </ul>	State Exchange	Monitor; receive status reports	1/14

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Educate all parties about health law	Inform the public and key stakeholders about policy changes and other reforms.	<b>Outreach and Education</b>			8/10
		<ul style="list-style-type: none"> <li>- Develop fact sheets and FAQs for all stakeholders (e.g., consumers, providers, businesses, insurers, etc) to clearly explain law and its implications</li> <li>- Hold forums across the state to assist in understanding of new law</li> <li>- Continue to provide outreach and education, particularly regarding eligibility for subsidies &amp; tax credits; as well as potential for penalties</li> </ul>	Steering Committee; ACHSD		
Wellness program grants	Raise awareness among small employers of grants (through 2015) to establish comprehensive wellness programs	<b>Prevention and Wellness</b>			1/11
		<ul style="list-style-type: none"> <li>- Develop materials describing availability of grants to small businesses</li> <li>- Participate with small business advocacy organizations in development of forums</li> <li>- Inform small employers or coalitions of small employers of ability to receive grant funding to develop a tool kit to assist businesses with establishing wellness programs or availability of tool kit developed through Dirigo</li> </ul>	GOHPF DHHS DECD		

Issue	State Role	Key Tasks	Lead Agency	Legislative Role	Due Date
Wellness incentives	Raise awareness among employers of the option to provide employees with rewards in the form of reduced premiums based on participating in a wellness program.	<ul style="list-style-type: none"> <li>- Develop materials describing options for employers to reduce premiums based on participation in wellness</li> <li>- Participate with business advocacy organizations in development of forums for businesses to describe opportunity</li> <li>- Eliminate co pays in public programs for preventive services and apply increased match.</li> </ul>	GOHPF; Bureau of Insurance; DHHS; State Exchange		1/13
Wellness through the Exchange	Consider applying to conduct a Wellness Demonstration project that applies rewards in the individual market; evaluate whether Maine's existing wellness initiatives are consistent with new wellness options.	<ul style="list-style-type: none"> <li>- Work with insurers to consider Wellness Demonstration in individual market;</li> <li>- Based on current practices and potential changes, determine whether to develop a demonstration project to reward with premium incentives</li> </ul>	GOHPF; State Exchange; Bureau of Insurance		1/14



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Health Care Disparities	Maintain focus on reducing health care disparities	<p>Quality</p> <ul style="list-style-type: none"> <li>- Ensure disparities are considered in quality improvement activities;</li> <li>- Enhance collection and reporting of data, including access and treatment data for people with disabilities</li> </ul>	DHA; MQF; MCDC		3/12
Medical malpractice	Consider applying for demonstration grant to develop alternatives to medical malpractice rules to reduce provider practice of defensive medicine	<ul style="list-style-type: none"> <li>- Work with key stakeholders (physicians, hospitals, and trial attorneys to develop a coalition to apply for demonstration grant</li> <li>- Consider if state can be a lead vs. play a supporting role</li> <li>- Assist leads in drafting of grants and by providing letters of support</li> </ul>	GOHPF; DHHS; Bureau of InsuranceDHA-MQF Trial Court	Provide legislative authorization for med mal demos	

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CLASS	Raise awareness among individuals and employers of the opportunity to save for the eventual need for long-term supports using payroll deductions in the Community Living Assistance Services and Supports (CLASS) program.	<b>Long Term Care</b> - Develop/distribute information to individuals and businesses about CLASS; - Promote CLASS at public forums and events - Conduct financial analysis on impact of CLASS on MaineCare long term care costs - Consult with BOI	DHHS	Inform	1/11
Indian Health Care Improvement Act	Consider amendments to Indian Health Care Improvement Act	<b>Indian Health</b> - Review Indian Health Care Improvement Act, which is reauthorized & amended in the PPACA - Consider impact of amended requirements on American Indians residing in Maine - Consider whether any corresponding changes are needed in Maine state law	Tribes; DHHS MCDC	Inform	8/10